Department of Veterans Affairs

Memorandum

Date: March 4, 2003

From: Director, Wilkes-Barre VA Medical Center (693/00)

Subj: Robert W. Carey Organizational Excellence Award Application

To: Clinical Program Manager (10Q), VACO Washington, D.C. 20420
ATTN: Annie Stein

1. Attached is the Wilkes-Barre VA Medical Center's application for the Robert W. Carey Organizational Excellence Award.

2. If you have any questions, please contact Vincent L. Riccardo, Jr., Staff Assistant to the Director, at (570) 830-7042.

Roland E. Moore

ROLAND E. MOORE

NOMINATION FORM

Application Organization

Name: Department of Veterans Affairs Medical Center

Address: 1111 East End Boulevard
Wilkes-Barre, PA 18711

Highest Ranking Official in Applicant Organization

Signature: Roland E. Moore

Name: Roland E. Moore
Title: Medical Center Director (00)
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Size of Organization

Number of Employees: * 1,020
Number of Sites: 7 (1 Medical Center, 6 Community Based Outpatient Clinics)

* This figure excludes fee basis and medical residents.

Official Point of Contact in Applicant Organization

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Department of Veterans Affairs
Medical Center
Wilkes-Barre, PA

Robert W. Carey
Organizational Excellence Award
Application
FY 2003

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Glossary of Terms

A

Access
Relational database management package included in Microsoft Office, which is installed on all DSS PC systems.

ADC (Average Daily Census)
Average number of patients cared for per day during the reporting period.

ALOS (Average Length of Stay)
Number of inpatient days for discharged patients divided by total number of discharges; equivalent to the average number of days for an inpatient episode of care.

Ambulatory Care
Medical treatment provided without an overnight hospital stay, including some forms of surgery; non-emergency examination, diagnosis, and treatment of medical conditions; and laboratory and other diagnostic testing. Synonymous with outpatient care.

Ancillary Systems
Ancillary imaging systems are specialty imaging systems that capture, store, and display images for a particular service. These are typically small systems, and often incorporate special purpose hardware related to areas like EKG interpretation, pathology, and endoscopy. These systems often have components that assist clinicians in creating procedure reports**.**

AAC
Austin Automation Center

ARC
Allocation Resource Center

ASCII (American Standard Code For Information Exchange)
A standard, seven-bit information coding system that assigns a number from 0 to 127 to each of 128 upper and lowercase letters of the alphabet, numbers, special characters, and control character.

ASCII File Download/Upload.
In general, a download/upload of pure ASCII text that involves no error checking. The most common example might be scrolling a FORUM mail message on your computer screen while capturing it to a file on your local disk drive.

Austin Automation Center (AAC)
A VA organization in Austin, Texas, which manages many of the VA's centralized databases and computer systems including financial (CALM, PAID, FMS) and medical (PTF, OPC) data.

B

Balanced Scorecard - A management instrument, which translates an organization's mission and strategy into a comprehensive set of performance measures that provide a framework for strategic measurement and management.

Basic Benefits Package
Usually the most limited set of health care services covered by an insurance provider in its plan option offering. Also, services determined to meet minimum requirements for medically necessary care authorized under specific legislation.

Basic Care
For Transfer Pricing Purposes all discharges will be separated into Long Term Care (LTC) and Basic Care. Basic Care includes all other discharge bed sections not included in definition of Long Term Care. (see Long Term Care)

Benchmarking
The process of continuously comparing and measuring an organization against business leaders anywhere in the world to gain information that will help the organization take action to improve its performance. It refers to processes and results that represent best practices and performance for similar activities, inside or outside the organization.

Business Plan
A plan developed to implement the strategic goals and objectives of a strategic plan at the business unit level of the organization. They include specific action plans that respond to short and long term strategic objectives.

C

C&P (Compensation and Pension)
The organizational component of the Veterans Benefits Administration that processes veterans' claims and administers payments for compensation and pension benefits.

CDR
Cost Distribution Report, RCS 10-0141– source of Patient Care Cost Data.

CIRN (Clinical Information Resource Network)
Software application that provides the ability to automatically deliver information intra-VHA and inter-VHA on a particular patient to every facility to where he or she has received care. The principle of the CIRN implementation is to support primary care on a network-wide basis; a secondary objective is to provide the clinical component of information systems supporting managed care.

Client/Server
A network relationship where there exists one or more central computers (servers) with resources available to all other computers (workstations) connected to the network.

Clinical Indicators
Indicators are measurements of important aspects of health care delivery processes or health outcomes for a specific patient cohort.

Clinical Pathways
A series of critical steps or events that clinicians determine to be crucial and necessary parts of the optimal management sequence for a specific disease entity that are believed to affect outcome.

Clinical Practice Guidelines
Systematically developed and scientifically based consensus statements about appropriate health care in specific clinical circumstances for practitioner and consumer decision-making.

Clinical Reminders
Clinical Reminders, introduced with Patient Care Encounter v1.0 (PCE), may be used to track and improve preventive health care for patients, by electronically reminding VA practitioners that specific actions such as examinations, immunizations, and mammograms should be performed by the clinician. A reminders definition uses a patient's age, sex, and medical history when evaluating when care was last given, when it is due next, and specific details about why the patient should or should not receive the care. Reminders can be defined to apply to all patients or to patients who have specific clinical findings. For example, the influenza vaccine is generally given to patients who are 65 or older. However, some patients fall into high-risk categories and should be given the vaccine at any age. The details of a reminder describe why the patient is at high risk and should be given the vaccine. PCE exported 40 pre-defined Clinical Reminders, including Diabetic Foot Examination, Seat Belt Education, Influenza Vaccine, Fecal Occult Blood Test, Cholesterol Screen, Tobacco Cessation Education, and Alcohol Abuse Education. In addition to the pre-defined clinical reminders, facilities may create site-specific clinical reminders, based on preferences specified by clinic, provider, facility, and VISN. With the emphasis on preventive care, Clinical Reminders are used to comply with requirements established for VISN Directors' performance criteria, clinical practice guidelines, and national standards such as those defined by the VA's National Center for Health Promotion and JCAHO accreditation evaluations.

Complex Care
A forecasted value based upon five years of data for all Complex Care patients.

Consults
Consult/Request Tracking, a Vist*A* package commonly known as Consults, is a component of CPRS. Consults can function as part of CPRS, independently as a stand-alone package (for management purposes only), or as part of TIU.

Core Process
The fundamental activities, or group of activities, so critical to an organization's success that failure to perform the process in an exemplary manner will result in deterioration of the mission.

COLA (Cost of Living Adjustment)
Increase in benefits to compensate for the rise in the cost of living due to inflation; usually provided on a yearly basis.

Compensation
The appropriate account that provides for compensation payments to service-connected disabled veterans and their survivors.

Cost
The present value surrendered or promised to be surrendered in the future, in exchange for goods and services rendered. Expired costs are expenses; unexpired costs are assets.

Cost per Discharge
Calculated by dividing total annual operating expenses for the hospital by the total number of inpatient discharges.

CPRS (Computerized Patient Record System)
Computerized Patient Record System, the **Vist*A*** package (in both GUI and character-based formats) that provides access to most components of the patient chart. CPRS v.1 has evolved from Order Entry/Results Reporting (OE/RR), a comprehensive umbrella package that includes progress notes, health summary, and consults, in addition to ordering capabilities for lab, pharmacy, radiology, diets, etc.

CPTs (Current Procedural Terminology)
Listing of codes and descriptions for procedures, services and supplies published by the American Medical Association. Used to bill insurance carriers.

Critical Pathways
Clinical management tools that organize, sequence, and time the major patient care activities and interventions of the entire interdisciplinary team for a particular case type, diagnosis, or clinical condition.

Customer
The person or group who establishes the requirement of a process and receives or uses the outputs of that process; or the person or entity directly served by the department/program or agency.

D

Database (Corporate Data Base, Administrative, Vist*A*, DSS)
Databases are organized collections of pieces of data.

Diagnosis
A written description of the reason(s) for the procedure, service, supply or encounter.

Direct Radiography (DR)
X-ray imaging where the image goes directly into an electronic imaging archival system with no reader or scanner bridging the middle.

Discharge Rate
The ratio of the number of inpatients treated to the client population base; usually expressed as a rate, inpatients per 1,000 veterans.

D/C Summaries
Discharge Summaries are a component of the patient chart and also part of TIU.

Document Imaging
Document imaging allows scanned paper documents to be stored electronically and viewed on workstations as part of the online patient record. The principal document imaging need of VHA facilities today is to collect and manage patient chart information that cannot be handled by CPRS such as signed advance directives and consent forms, handwritten flow sheets, copies of outside medical records documents, etc.

DRG (Diagnosis Related Group)
A system of classifying patients according to type of disease.

DSS (Decision Support System)
DSS is a secondary relational database that fundamentally differs from existing VA transaction departmental database systems in that it integrates selected elements from each patient's resource utilization and clinical outcome data in a longitudinal format. The DSS database is extracted from existing VA clinical and administrative data systems (i.e., DHCP, PTF, FMS, DALM, PAID, CMR). DSS is an executive information system.

E

Effective
Refers to how well an approach, a process, or a measure addresses its intended purpose.

Eligibility
Eligibility criteria are categorized by service-connected status, income levels, and other factors; eligible veterans may receive VA health services if space and resources are available. Service-connected veterans are eligible for the full spectrum of VA medical care services.

Encounter (Clinical)
A paper form used to display data pertaining to an outpatient visit and to collect additional data pertaining to that visit.

Enhanced Use
A leasing agreement whereby unoccupied or underoccupied VA facilities lease space to external parties for activities that will benefit VA.

Entitlement
An unequivocal, statutory commitment by Congress to provide a specific benefit, such as health care, to certain populations who meet the eligibility criteria established by law. VA is required to provide benefits to those veterans who are entitled to programs under Veterans Benefits Administration criteria and inpatient and some forms of outpatient care to veterans entitled to VA medical care system treatment.

Environmental Scan
A method used to Identify external and internal factors that may potentially affect the organization.

Event Capture System (ECS)
A DHCP Class 1 software application that allows you to collect data not previously captured by other means.

External Customer
An individual or group outside the boundaries of the producing organization who receives or uses the output of the process.

F

Filmless Radiology
Filmless radiology systems are generally called Picture Archiving and Communications Systems (PACs) and support image acquisition, image storage on short and long term storage devices, display of images for diagnostic interpretation, display of images for clinicians reference and review, printing of images, workflow management for study interpretation, and some report handling. These systems use high resolution workstations and high-speed servers to allow radiology departments to operate without making x-ray film.

Financial Management Report
Canned report run out of KLF menu thru AAC.

Fixed Costs
Costs that remain substantially the same in total amount within a relevant range of activity during a given period of time.

FTE (Full - Time Employee)
FTEE (Full - Time Employee Equivalent)
Full-time equivalent employment of personnel that includes part-time employees. One FTEE equates to 2,080 man-hours worked in a fiscal year.

FTEE's/Adjusted Occupied Bed
Total paid full-time equivalent employees/occupied beds x gross patient revenue/gross inpatient acute care revenue.

G

Gainsharing
Plans based on a formula that shares some portion of gains in productivity, quality, cost-effectiveness, or other performance indicators. The gains are shared in the form of bonuses with all employees in an organization. It differs from profit sharing and an ESOP in that the basis of the formula is some set of local performance measures, not corporation profits.

GPRA (Government Performance Review Act)
Public Law 103-62 Government Performance Review Act of 1993. This Act requires all federal agencies to plan strategically, develop performance plans, and performance measures related to goals and to report their performance against the plans.

Graphical User Interface (GUI)
A means of communicating with your computer by simply pointing at easy-to-understand menus and pictures (icons). A Windows-like screen that uses pull-down menus, icons, pointer devices, and other metaphor-type elements that can make a computer program more understandable, easier to use, allow multi-processing (more than one window or process available at once), etc.

H

HBHC (Hospital-Based Home Care)
Programs that allow the early discharge of chronically ill veterans to their own homes.

HCMI (Homeless Chronically Ill Veterans Program)
A VA outreach program that identifies and serves homeless, chronically mentally ill veterans.

Health Summary
A **Vist*A*** package that pulls selected components of data from other **Vist*A*** packages to present a summary of a patient's health care, including clinical reminders. It can be viewed through CPRS reports.

Historical PRPs
The workload associated with care provided to all patients. (Basic and Complex) for a fiscal year. Historical PRPs can be reported at the facility, VISN or national level.

Hospice Program
Provides inpatient palliative care for terminally ill patients.

HTML
Hyper Terminal Markup Language

I

ICD9 (International Classification of Diseases)
Is a statistical classification system that arranges diseases and injuries into groups according to established criteria.

Imaging
A **Vist*A*** program and a component of the patient chart that includes Radiology procedures, X-rays, and Nuclear Medicine and other clinical images such as EKGs, images captured from microscopes, endoscopes, digital cameras and scanned documents.

Indirect Expense
An expense that is incurred for an entire facility as a unit and that is not subject to the control of individual program leaders.

Inpatient Services
Those services that require patient admission to a health care facility.

Integration
Refers to the harmonization of plans, processes, information, resource decisions, actions, results, analysis, and learning to support key organization-wide goals.

Intermediate Care
A medical bed section in a VA hospital that serves as a reservoir for patients with intensive care needs of chronic illness.

Internal Customer
An individual or group inside the boundaries of the producing organization who receives or uses the output from a previous stage or process to contribute to production of the final product or service.

IRM (Information Resource Management)
An entity responsible for managing the system's or department's databases and computer resources. A strategy based on the principle that information is a resource that should be managed from the highest level of the organization.

J

JCAHO (Joint Commission on Accreditation of Health Care Organizations)
Provides criteria and surveys hospitals for accreditation. Accreditation affirms that an organization has met standards that are associated with quality health care delivery. VA voluntarily complies with JCAHO standards.

K

Key Performance Indicator
Measurable factors of extreme importance to the organization in achieving the strategic goals, objectives, vision, and values that if not implemented properly would likely result in a significant decrease in customer satisfaction, employee morale, and financial management.

KLF
Requires access through the Austin Automation Center. Contains the following data elements: Performance Measures, Workload Reporting, Financial/Resource Management Reports, RPM Data, and Quality Assurance/Utilization Review Reports. (Developed by Kathy L. Frisbee)

L

LAN
Local Area Network

Long-Term Care
Non-acute care services that require more than 30 days of treatment. For Transfer Pricing purposes all discharges are separated into Long Term Care (LTC) and Basic Care. Long Term Care includes: 85– Domiciliary, 86 - Domiciliary Substance Abuse, 87 – GEM Domiciliary, 88 – Domiciliary PTSD, 80 – Nursing Home Care Unit, 81- GEM Nursing Home, 33- GEM Psychiatry, 92 – General Intermediate Psychiatry, 93 - High Intensity General Psychiatry, 32- GEM Intermediate Care and 40 – Intermediate Medicine.

LOS
Length of Stay

M

Major Construction
VA construction projects costing $4 million or more; also refers to the appropriation account that funds such projects.

MAN
Metropolitan Area Network

Managed Care
A system of healthcare delivery that manages the utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

MCCR /MCCF(Medical Care Cost Recovery)
A program to collect veteran co-payments and reimbursable costs from third-party insurers for medication and health care services delivered by VA.

Measure
One of several measurable values that contribute to the understanding and quantification of a key performance indicator.

Medicaid
A Medical Assistance Program funded by the Federal and State governments. Under Federal regulations provided by the Health Care Financing Administration (HCFA), each state administers Medicaid benefits to "categorically needy" individuals who receive public assistance because they are poor, aged, blind, or disabled. States may also provide Medicaid services to the "medically needy," who have incomes too high to be considered "categorically needy" yet are still unable to afford health care coverage.

Medicare
A program administered by the Health Care Financing Administration; pays certain hospital and medical expenses for those who qualify, primarily those over age 65 and individuals with disabilities. Benefits are provided regardless of income level. Medicare Part A, Hospital Insurance (HI), provides for inpatient hospital services and post-hospital care. Part B, Supplemental Medical Insurance (SMI), pays for medically necessary doctor's services and other services and supplies Part A does not cover. Enrollment in Part B is voluntary and available for a premium.

Metric
The elements of a measurement system consisting of key performance indicators, measures, and measurement methodologies.

Microsoft Office
An integrated suite of computer applications that generally include a database (Access), a spreadsheet (Excel), a word processor (Word), and other packages.

Minor Construction
VA construction projects costing less than $4 million; also refers to the appropriations account that funds such projects.

Mission
An enduring statement of purpose, the organization's reason for existence. Describes what the organization does, whom it does it for, and how it does it.

Modem
A device used to communicate with remote computer systems, often over standard telephone lines.

MS Office
The current market leader in suites sales and usage is the Microsoft Office. The MS Office Professional Suite is made up of the following products: Microsoft Access (Database Management System or "DBMS"), WORD (Word Processing), EXCEL (Spreadsheet), and Power Point (Presentation Graphics).

N

NDAIO
Network Data Analysis and Information Office. The NDAIO (previously known as Network Business Office (NBO)) was established in August 1997 and is a network resource that supports the gathering and reporting of information on a variety of data, information and reports. The staff has a wide variety of backgrounds to provide customers with administrative, clinical, technical and managerial expertise. The staff manipulates, extracts, and consolidates databases to produce spreadsheets, graphs and reports to help VISN staff or individual facilities/programs analyze costs, workload, initiatives and to project initiatives.

NBO
Network Business Office. The NBO was established in August 1997 and is a network resource that supports the gathering and reporting of information on a variety of data, information and reports. The staff has a wide variety of backgrounds to provide customers with administrative, clinical, technical and managerial expertise. The staff manipulates, extracts, and consolidates databases to produce spreadsheets, graphs and reports to help VISN staff or individual facilities/programs analyze costs, workload, initiatives and to project initiatives.

No Show
Patient who did not report for scheduled appointment w/o previously notifying the facility.

Nonservice-Connected (NSC) Patients
Veteran patients who do not have a military service related injury or illness.

O

Occupancy Rate
Ratio of average daily census to the average number of beds in a reporting period.

OE/RR
Order Entry/Results Reporting, a **Vist*A*** package that evolved into the more comprehensive CPRS.

Outcome
The way the customers respond to products or services.

Outpatient Care
See Ambulatory Care.

Outpatient Visit
The visit of an outpatient to one or more units or facilities located in or directed by the provider maintaining the outpatient health care services (clinic, physician's office, hospital/medical center) within one calendar day.

Outpatient Use Rate
Ratio of outpatient visits to the total veteran population, expressed as visits per veteran.

Outpatient Visits
Visits by patients who are not lodged in the hospital while receiving medical, dental, or other services. In the VA health care system, a visit may consist of one or more clinic stops. (Each test, examination, treatment, or procedure rendered to an outpatient counts as one clinic stop.)

Output
The products or services produced by a process.

Overbook
A clinic appointment which is made when there are no available dates and times.

P

Panel Size
List of Patients – The number of active patients in the team's patient panel.

Patient Assessment File (PAF)
Contains the resource utilization group (RUG II) assignments for all VA Long Term Care patients.

Patient Assessment Instrument (PAI)
Formal evaluation and documentation of a long-term care patient's ability to perform activities of daily living. Used to assess the level of skilled nursing required for the patient's support conducted upon admission and at six-month intervals by nursing staff.

Patient Day
The unit of measure denoting lodging facilities provided and services rendered to one inpatient between the census-taking hour on two successive days

PCE
Patient Care Encounter

Patient Treatment File (PTF)
Principal source of inpatient workload data. It is a computerized abstract of every inter-hospital transfer and every patient discharged from a VA facility.

PCMM
Primary Care Management Module

Pensions
The appropriations account that provides for pension payments, subject to an income standard, to war-time veterans who are permanently and totally disabled from nonservice-connected causes and their survivors.

Progress Notes
A component of TIU, which functions as part of CPRS. Progress Notes are clinicians' textual records of apatient's status at the time of an encounter.

Practice Standards
Specified principles, resources, and procedures for which there is professional consensus regarding the health and economic consequences and benefits of intervention.

Process
Refers to linked activities with the purpose of producing a product or service fro a customer (user) within or outside the organization.

Progress Notes
A component of TIU, which functions as part of CPRS. Progress Notes are clinicians' textual records of a patient's status at the time of an encounter.

Prospective Payment
Method of payment in which rates of payment are established in advance for a designated period of time. A measure of workload based on the proportionate distribution of **cost.** The PRP (Pro-Rated Patient) for any given patient will equal a maximum value of 1.0.

Provider
A business entity which furnishes health care to a consumer; it includes a professionally licensed practitioner who is authorized to operate a health care delivery facility. For VHA purposes, a VHA medical center to include its identified division and satellite clinics is considered to be the business entity furnishing health care at the organizational level. Sub-

organizational level entities will include treatment teams and individually identified practitioners. For purposes of the National Patient Care Database (NPCD), a VHA-defined
practitioner type field will be reported together with the medical center and medical center division

code.

PRP
Pro-Rated Patient

PSAS (Prosthetics and Sensory Aids Service)
The entity within VHA whose goal is the provision of prosthetic and orthotic appliances and sensory aids to veterans.

PTSD (Post -Traumatic Stress Disorder)
A psychiatric condition caused by a traumatic experience, such as combat.

Q

R

RAM (Resource Allocation Model)
Formerly used system for distribution of resources in VA system based on diagnostic related groups (DRG's).

Relative Value Unit
Index numbers assigned to various procedures based on the relative amounts of labor, supplies and capital required to perform the procedure.

Reports
A component of the patient chart that includes health summaries, action profiles, and other summarized reports of patient care.

Respite Care
Programs under which the elderly or people with disabilities are institutionalized periodically to allow a relief period for the patient's care-giver.

Retrospective Payment
Method of payment in which payment is made for covered services rendered during a preceding period and considered as reasonably incurred costs.

Return on Investment
Net income/Equity

Revenue
Revenue results from the rendering of services and is measured by the charge made to the patients for goods and services furnished to them. It also includes gains from the sale or exchange of assets, interest and dividends earned on investment, and unrestricted donation of resources.

RPM (Resource Planning and Management)
Strategy formulated by VHA to achieve comprehensive integration of strategic and operational planning, budgeting, and operational management of the VA health care system.

S

Secondary Care
Therapy for acute short-term illness or injury.

Self-Managed Work Teams
Also termed autonomous work groups, semiautonomous work groups, self-regulating work teams, or simply work teams. The work group is responsible for a whole product or service and makes decisions about task assignments and work methods. The team may be responsible for its own support services and may perform certain personnel functions.

Semi-Fixed Costs
Costs that are partly variable and partly fixed in behavior in response to changes in volume.

Service-Connected Patients
A veteran with conditions resulting from illness or injuries sustained during military service.

Sessions
Blocks of time (group of slots) in which a provider schedules in their patients.

Shared Uniques
The actual number of patients seen as opposed to the total number of visits (Patients counted more than once; i.e., one time for each station).

Sharing Agreements
Refers to federal agencies sharing health care services (usually high-cost or high-technology services) with community or private sector providers or with other federal agencies. These agreements have legislative authority.

Slots
An increment of time set aside; i.e., to see a patient.

SQL Server
Structured Query Language

Stakeholder
Any person, group, or organization that can place a claim on, or influence, the organization's resources or outputs, is affected by those outputs, or has an interest in or expectation of the organization.

Statistical Analysis System (SAS)
A database management system and database query language. VA inpatient and outpatient databases are stored in SAS files on the Austin mainframe and accessible via the SAS query language. The SAS query language can also be used to access non-SAS files.

Stop Code
A three digit number that is used in VHA to identify the services that a patient receives at a Department of Veterans Affairs (VA) medical facility within a 24-hour period. Stop codes are also used to capture workload statistics. For example, a patient treated in the admissions/screening unit will be reported in stop code 102, which includes the physician's services; if a general medicine physician provides consultative services to the patient, then stop code 301 may also be reported. The term DSS identifier is now used instead of stop code.

Strategic Goal
A long-range change target that guides an organization's efforts in moving toward a desired future state.

Strategic Objective
A broad time-phased measurable accomplishment required to realize the successful completion of a strategic goal.

Strategic Planning
The continuous and systematic process whereby guiding members of an organization make decision about its future, develop the necessary procedures and operations to achieve that future, and determine how success is to be measured.

T

Teleradiology
Teleradiology systems are telemedicine systems that electronically transmit radiology images from one location to another for the purposes of interpretation and/or consultation. Teleradiology systems are generally used by radiologists and nuclear medicine physicians or by other specialists such as orthopedic surgeons, depending on the site's needs.

Tertiary Care
Definitive therapy for major illness or injury, utilizing specialized professional skills and techniques.

Team Incentives
Bonuses or other financial compensation tied to short-term or long-term team performance.

Third-Party Reimbursement
Payment for health care services by an interest other than the patient or provider, such as an insurance company or the government.

TIU
Text Integration Utilities; a **Vist*A*** package for document handling, that includes Consults, Discharge Summary, and Progress Notes, and sometimes other document types such as surgical op reports. TIU components can be accessed for individual patients through the CPRS, or for multiple patients through the TIU interface.

Transfer Pricing
The VISN 4 Transfer Pricing Program assigns patients to VISN 4 facilities based on zip code residence without regard to the "preferred facility" field in **Vist*A***.

U

Uncompensated Care
Refers to hospital care that is provided for which the hospital receives no payment from a patient or insurer. It is the sum of a hospital of a hospital's "bad debt" and the charity care it provides.

Unique SSN
The actual number of patients seen as opposed to the total number of visits. (Each patient counted once).

V

VA (Department of Veterans Affairs)

Values
Refers to the guiding principles and or behaviors that embody how the organization and its people are expected to operate. Values reflect and reinforce the desired culture of an organization, support decision making, and help the organization accomplish its mission and vision.

VAMC (Veterans Affairs Medical Center)
One of the 163 hospitals dedicated to administering veteran's health benefits.

VA Cost Center
A three-digit number designating a specific service at the lowest functional level without regard to programs. Cost centers are established to permit consolidation of appropriations available to VA. An 8 representing (VHA) precedes the cost center, e.g., 8201 = Medical Service.

Variable Costs
A cost which varies directly in total with changes in the level of activity.

VERA (Veterans Equitable Resource Allocation)
Replaces RPM, prices resources under two groups, basic and special care, (rather than five used with RPM) and it provides data at the encounter level.

VERA PRP
Used for allocating resources to VISNs, they are calculated differently for Basic and Complex Care patients.

VHA (Veterans Health Administration)
The VA agency responsible for delivery of medical care.

Virus Software
Software designed to detect computer viruses.

Visit
Any number of stops or encounters in a single calendar day.

VISTA
Veterans Health **I**nformation **S**ystems and **T**echnology **A**rchitecture, formerly known as DHCP, the comprehensive, integrated computer system used in the VA Medical Centers, describes the automated environment at local VA health care facilities that supports day-to-day operations.

VSO (Veterans Service Organization)
An organization advocating the rights of veterans.

W

Webpage
The Business Office's Webpage Address is 152.128.95.15

Wide Area network (WAN)
Usually a moderate/larger-sized network in which communications are conducted over telephone lines using modems. May also employ gateways and packet-switched networks.

WIN 95/97
Operating System which uses graphical user interface (GUI) that uses pictures of familiar objects, such as file folders and documents to represent a desktop on your screen. Has rectangular shaped work areas, called "windows," that appear on the screen.

WIN NT
The new Windows 95 interface makes it easier and faster to do work. It includes such features as Microsoft Windows NT Explorer, which makes finding and storing files easier. New features in Windows NT Workstation 4.0 are: Windows 95 User Interface, Telephony API and Unimoden, NetWare 4 Client and Logon Script Support, Peer Web Services, Microsoft Internet Explorer, Distributed Applications for the Internet, Windows Messaging and Direct Draw and Direct Sound Support.

X Y Z

830 Reports
Monthly report for costs and FTEE by BDOC.

XII. Acronym Listing

Acronym	Meaning
AC	Ambulatory Care
ACOS	American College of Surgeons
ADP	Automated Data Processing
ADPAC	Automated Data Processing Application Coordinator
AMIE	Automated Medical Information Exchange
ANSI	American National Standards Institute
AP	Anatomic Pathology
AR	Accounts Receivable
ASI	Addictive Substance Interview
C&P	Compensation & Pension
CAC	Clinical Application Coordinator
CALM	Centralized Accounting for Local Mgmt (replaced by FMS)
CARES	Capital Asset Realignment for Enhanced Services
CARF	Commission on Accreditation of Rehabilitation Facilities
CAT	Computerized Axial Tomography
CBOC	Community Based Outpatient Clinics
CIO	Chief Information Officer
CIOFO	Chief Information Office Field Office
CIRN	Clinical Information Resources Network
CMOP	Consolidated Mail Outpatient Pharmacy
COS	Chief of Staff
COTS	Commercial Off-the-shelf products
CPRS	Computerized Patient Record System - formerly OE/RR
CPT	Current Procedural Terminology
CPU	Central Processing Unit
DEA	Drug Enforcement Agency
DHCP	Decentralized Hospital Computer Program Dynamic Host Control/Configuration/Communication Protocol
DMMS	Decentralized Medical Management System
DOB	Date of Birth
DoD	Department of Defense
DOM	VA Domiciliary
DPC	Austin Data Processing Center
DSS	Decision Support System
DSS	Document Storage Systems (vendor)
DUE	Drug Use Evaluation
FIPS	Federal Information Processing Standards
FIRMAC	Field Information Resource Mgmt Advisory Committee
FM	VA FileMan
FMS	Financial Management System
FTEE	Full-time Employee Equivalent
GAO	General Accounting Office

Acronym	Meaning
G-CPRS	Government Computerized Patient Record System, a VA, DOD, HIS project to integrate the automated patient record
GRECC	Geriatric Research, Education and Clinical Center
GUI	Graphical User Interface
HCFA	Health Care Financing Administration
HCHV	Health Care For Homeless Veterans
HEC	Health Eligibility Center
HIMSS	Health Information Management System Society
HINQ	Hospital INQuiry
HOST	Hybrid Open Systems Technology
HPDM	High Performance Development Model
HSR&D	Health Services Research & Development
ICD-9	International Classification of Diseases, 9th ed.
IFCAP	Integrated Funds Distribution, Control Point Activity
IG	Inspector General
IM	Information Management
IRM	Information Resources Management
IT	Information Technology
JCAHO	Joint Commission on Accreditation of Hospitals
LAN	Local Area Network
LC	Leadership Council
LEDI	Laboratory Electronic Data Interchange (a new module of Lab that allows labs to send data to each other)
LTC	Long Term Care
MAC	Management Assistance Council
MAN	Metropolitan Area Network
MAS	Medical Administration Service - now PIMS
MCCR	Medical Care Cost Recovery
MIS	Medical Information Section
MRT	Medical Record Technician
MUMPS	Massachusetts General Hospital Utility Multiprogramming (now M)
NDF	National Drug File
NOIS	National On-line Information Sharing system
OE/RR	Order Entry / Results Reporting - now CPRS
OIG	Office of Inspector General
OPC	Outpatient Clinic
PAID	Personnel & Accounting Integrated Data
PCE	Patient Care Encounter
PCMM	Primary Care Management Module
PDM	Pharmacy Data Management
PDX	Patient Data Exchange
PIMS	Patient Info Mgmt System (?) - formerly MAS (AD/R) & SD
PL	Problem List
PM&R	Physical Medicine & Rehabilitation Services
PMIS	Patient Medication Information Sheet

Acronym	Meaning
PN	Progress Notes
PTF	Patient Treatment File
QUIC	Quality Improvement Checklist
RAM	Random Access Memory
SQL	Structured Query Language
SWOT	Strengths, Weaknesses, Opportunities, Threats
T&A	Time and Attendance
T&L	Time & Leave Unit
TCP/IP	Transmission Control Protocol/Internet Protocol
UR	Utilization Review
VA	Department of Veterans Affairs
VACO	VA Central Office (headquarters)
VALNET	VA Library Network
VARO	VA Regional Office
VHA	Veterans Health Administration
VIC	Veterans Identification Card
VISN	Veterans Integrated Service Network(s)
VISTA	Veterans Health Information System & Technology Architecture
VPOE	VISN Planning, Operations and Evaluation Committee
WAN	Wide Area Network
WWW	World Wide Web

ORGANIZATIONAL PROFILE

P.1 Organizational Description – The Department of Veterans Affairs has three major areas: Veterans Health Administration (VHA), Veterans Benefit Administration and National Cemetery Administration. Within VHA, there are 21 Veterans Integrated Service Networks (VISN) that provide health care services to the nation's veterans. The Wilkes-Barre VA Medical Center (WBVAMC) is one facility among ten within the VA Stars & Stripes Healthcare Network. In FY 02, the WBVAMC's primary service area consists of 19 counties in Northeastern Pennsylvania, having a veteran population of 206,758 that covers over 13,300 square miles. In addition, it serves veterans in Southern New York State. A number of counties served are identified as health professional shortage areas in primary care (Columbia, Lycoming, Monroe, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Union, and Wayne). Community Based Outpatient Clinics are located in Allentown, Columbia County, Sayre, Schuylkill County, Tobyhanna, and Williamsport. WBVAMC is a General Medical and Surgical facility and is affiliated with Drexel University College of Medicine and the Pennsylvania College of Optometry. A new medical affiliation began in FY 02 with the Lake Erie College of Osteopathic Medicine. The facility also supports 71 affiliations with other colleges, universities, and schools of allied health. Several special programs offered at the WBVAMC include; a Hemodialysis Unit, Outpatient Post-Traumatic Stress Disorder Program, Home Based Primary Care, Healthcare for Homeless Veterans Program, Mental Hygiene Clinic, Polysomnography Laboratory, Short Procedure Unit, Same Day Surgery Program, Women's Health Program, Step-Down Unit, 23-Hour Observation Beds, Substance Abuse Residential Rehabilitation Treatment Program (SARRTP), Halfway House, and Visual Impairment Services. The extended care program encompasses a Nursing Home Care Unit, a Geriatric Evaluation and Management Program, a Rehabilitation Unit, a Dementia Unit, a Hospice Unit, and Respite and Residential Care Programs. Persian Gulf, HIV, Ex-POW, sexual abuse and spiritual counseling as well as psychological testing, and behavior management modification are other examples of the diverse services provided by WBVAMC. There are Vet Centers located in Scranton and Williamsport.

The WBVAMC has a number of sharing agreements to provide health care services to such organizations as the Department of the Navy, the Lehigh Valley Naval/Marine Reserve Center, the Tobyhanna Army Depot for both active duty and civilian employees; the United States Navy and Marine Corps, Wilkes-Barre area; and the Department of the Army, 99th Regional Support Command, in Oakdale, Pennsylvania.

P.1a. Organizational Environment – P.1a(1). Main Health Care Services - The WBVAMC provides a Uniform Benefits Package through its multiple care delivery access points (Figure O.1).

Comprehensive Care	❖ Primary Care ❖ Surgical Care ❖ Long Term Care ❖ Behavioral Health Care ❖ Acute Care ❖ Clinical & Diagnostics Svcs. ❖ Physical Medicine ❖ Rehabilitation & Prosthetics	❖ 116 Inpatient Hospital Beds ❖ 165 Nursing Home Beds ❖ 10 SARRTP Beds ❖ 6 CBOC's ❖ Fee Basis & Contracted Vet Centers (Scranton & Williamsport)	Place Quality First Easy Access to Care Enhance Patient Functioning Exceed Patient Expectations Maximize Resources Build Healthy Communities
Support Operations	❖ Education ❖ Quality Improvement ❖ Health Administration Service (including Info Management) ❖ Facility Management ❖ Financial Management ❖ Human Resources	❖ Affiliations with Medical Schools, Colleges, Universities & Schools of Allied Health	Place Quality First Easy Access to Care Enhancing Patient Functioning Exceeding Patient Expectations Maximizing Resources Building Healthy Communities

***Figure O.1 Core Businesses** and Delivery Processes*

P.1a(2) Organizational Context and Culture – Since 1950, the Wilkes-Barre VAMC has strongly supported veterans and their communities. Its culture focuses on maintaining and improving health care to veterans in a cost effective manner (Figure O.2).

Purpose	Mission	Vision	Values
"To care for him who have born the battle and for his widow and his orphan." ***Abraham Lincoln***	To maintain and improve veterans' health and quality of life.	To be a national leader in the provision of health care services.	Trust Respect Excellence Commitment Compassion

Figure O.2 Purpose/Mission/Vision/Values

P.1a(3) Employee Profile – In an effort to continually enhance the workplace environment, a recent cultural transformation has and continues to occur. Employees (Figure 0.3 and 0.4) have adapted the philosophy of the Stephen Covey principles as well as organized its operations around Baldrige Criteria. The Covey principles emphasized include: being proactive; beginning with the end in mind; putting first things first; thinking win-win; seeking first to understand, then to be understood; synergizing; and, sharpening the saw. The development of the workforce and patient diversity are critical components to the success of the organization. Continuous efforts are made to provide educational opportunities for employees as well as seeking diversity within the workforce. Greater resources have been utilized for employee training. More employees have utilized training opportunities, and recruitment/retention efforts have aimed at a highly skilled workforce particularly in specialties considered to be in short supply and heavily competitive (e.g. Urologist, Radiologist, Contracting Officer, Human Resource Specialist.). Our union partners assist us to accomplish more by properly shifting resources to where more clinicians are face-to-face with patients. We have one of the lowest cost per unique patient rates within the Network.

We have staff trained and certified to meet safety requirements in such areas as First Response in hazardous materials and in asbestos removal. We conducted a hazard analysis of all positions. As a result, different positions were identified to have special protective needs; e.g. electricians, plumbers, nurses, lab and radiology techs and housekeeping. Furthermore, in order to meet periodic yet critical patient support needs, we have 54 clinicians in the community who serve as consultants.

	Employees	Contracted Employees		Employees	Contracted Employees
Less Than High School	14	1	Master's Degree	80	1
High School Graduates	409	72	Dentists	5	5
Associate's Degree	133	4	MD's	116	29
Nursing Diploma	69	0	DO's	4	2
BS Nursing	45	0	Professional Degrees	9	3
Bachelor's Degree	114	2	Doctoral Degrees	11	0
			Total	**1009**	**119**

Figure O.3 Employee Profile: Education Level

P.1a(4) Major Technology, Equipment, and Facilities – The WBVAMC utilizes an integrated framework to continue aligning information technology, equipment and facilities with strategic objectives and core business lines (Figure O.5). Major components and alignments have been introduced.

	Employees	Contracted Employees		Employees	Contracted Employees
Health Care Providers	126	36	Allied Health Support Staff	215	14
Nursing Staff	218	0	Trade Craft Workers	120	0
Other Clinical Providers	50	4	Administrative Staff	345	0
			Total	**1074**	**54**

Figure O.4 Employee Profile: Occupation

Item	Functions
❖ Computerized Patient Record System (CPRS)	❖ Electronic Medical Record
❖ Semi-Integrated Database for Patient Care Data/Information	❖ Patient Data Integration
❖ Bar Code Medication Administration	❖ Patient Safety
❖ New Clinical Addition – Approximately 25,000 square feet	❖ Additional Outpatient Clinics
❖ Recent Major Renovation to Three Inpatient Wards	❖ Patient Ward Renovations

Figure O.5 Major Technology/Facilities

P.1a(5) Regulatory Environment - The Medical Center operates in a highly regulated governmental healthcare environment. As a federal agency, the facility experiences significant oversight by federal congressional and other executive entities. Federal, state, and non-federal requirements affect operations to ensure the facility meets standards for health care delivery. The Medical Center is in full compliance with all external accreditation bodies (Figure O.6 and 7.1-14).

Regulatory/Accreditation	JCAHO, CAP, AABB, CARF, FDA, NRC	HAP, LTC, Rehabilitation, Laboratory, Home Care, Health Care for Homeless Veterans	Quality Mgmt/Performance Improvement
Legal	Compliance	HIPAA	Compliance Officer
Product Risks	OSHA	Medical Waste Disposal/Product Recalls	Safety Committee, Safety Officer
Service Risks	Patient Safety	Aggregate Reports/RCA	Patient Safety Officer
Operational Risks	EPA	OWCP/Lost Times Claims	Safety Officer, Contracting Officer

Figure 0.6 Regulatory Environment

P.1b. Organizational Relationships – P.1b(1) Customer Groups and Requirements - While any veteran may enroll, our primary customer groups are uninsured veterans and/or veterans with special disabilities and a smaller group of insured veterans for whom WBVAMC is the provider of choice. The U.S. Congress has also segmented military service veterans into eight categories or priority groups. If space permits, veterans with service-connected disabilities, former POWs, and those whose income and net worth are below an established dollar threshold receive the highest priority for care.

Within the context of the eight veteran categories, WBVAMC's customer requirements are organized by level of care and special patient populations that cut across these eligible populations of veterans (Figure O.7). Customer requirements are identified within primary care, inpatient services and nursing home care, for general medical and medical health populations, and for special care groups of patients. There is a common set of customer requirements across these populations.

Key Customer / Supplier Groups Market Segments	Key Service/Product Requirements	How Requirements Differ
Customer/Patient Groups: - Primary Care - Acute Care - Long Term Care - Behavioral Health Care - Specialty Care	- Timeliness – Waiting Times, Response Times - Courtesy – Satisfaction Surveys - Access – Proximity to Care, Waiting Times - Emotional Support – Satisfaction Surveys - Quality – Performance Indicators/Measures	- Age - Gender - Geographic Location - Period of Military Service - Special Needs (Women's Health, Substance Abuse, Homeless, Blind Amputee, Spinal Cord Injury, Traumatic Brain Injury)

Figure O.7 Key Customer Groups

P.1b(2) and (3) Supplier and Partnering Relationships – The WBVAMC has developed numerous agreements with community agencies and organizations, resulting in mutual benefits for all parties. Projects have included a joint ownership of an MRI with the Geisinger-Wyoming Valley Health Care System, community residential care arrangements and transitional homeless veteran units (8 beds) with the Commission on Economic Opportunity.

Major Suppliers Types	Requirements	Communication Mechanisms
Medical and Allied Health Affiliations	Quality of Care	Meetings, Telephone, Writing
Medical and Prosthetic	Quality/Timeliness/Access	Meetings, Telephone, Writing
Pharmaceutical, Food, Nutrition	Response Time	National/Local Vendor Contracts, Meetings, Telephone, Writing
Medical Equipment	Quality, Responsiveness	Meetings, Telephone, Writing
Computer and Office	Quality, Responsiveness	Telephone, Writing
Contractors (Construction and Others)	Timeliness, Safety	Telephone, Writing, Site Visits, Meetings
Community Health Providers	Quality, Responsiveness	Telephone, Meetings

Figure 0.8 Major Suppliers

P.2 Organizational Challenges – P.2a Competitive Environment – P.2a(1) Competitive Position – In FY 01, WBVAMC served 31,338 individual veterans equating to a 14.8% market share. In FY 02, the market share grew to 17.3%. (Figure O.9). WBVAMC is part of VA's concerted effort to plan for the future health care needs of veterans called Capital Asset Realignment for Enhanced Services (CARES). As partial outcome of this effort, this has indicated a 36.5% increase in stops for primary care for FY 12; a 79.3% increase in stops for specialty care and a 19.2% increase in bed days of care for inpatient medicine. This demand is expected to occur despite a projected decrease in veteran population.

Year	Veteran Population	Uniques Served	Market Share	Competitors	Key Collaborators
2001	212,074	31,338	14.8%	❖ Geisinger Health Care System ❖ Wyoming Valley Health Care System ❖ Mercy Health Care System ❖ Insurances: Blue Cross/Blue Shield, Geisinger Health Plan	❖ Affiliates ❖ State Homes ❖ Veteran Service Organizations ❖ Dept. of Defense ❖ Competitors
2002	206,758	35,843	17.3%		

Figure O.9 Competitive Environment

Key Business Drivers (Critical Success Factors)	Changes Leading to Opportunities
❖ Placing Quality First ❖ Easy Access to Care ❖ Enhancing Patient Functioning ❖ Exceeding Patient Expectations ❖ Maximizing Resources ❖ Building Healthy Communities	❖ Demographics ❖ Millennium Act ❖ Congressional Legislation ❖ U.S. Economy ❖ U.S. Health Care Climate and Costs

Figure O10 Key Business Drivers

P.2a(2) Principal Success Factors – In concert with WBVAMC's mission, vision and values; the facility elected through its strategic planning process, six major drivers as found in VHA's Six for 2007 goals (Figure O.10).

P.2b Strategic Challenges – Figure O-11 reflects a summary of challenges facing the Medical Center. Strategic objectives identified in the facility's Strategic Plan and Balanced Scorecard (figure 1.3) address these challenges. These objectives are further delineated into action plans for each Service to implement.

P.2c Performance Improvement System – P.2c(1) Performance Measurement Program (PMP) - The Medical Center strives to improve patient care outcomes and administrative services through a comprehensive performance improvement program that uses a collaborative, interdisciplinary approach. The program assures systematic measurement, assessment, and improvement of processes and performance. The processes include mechanisms to assess the needs and expectations of key constituents. Performance improvement efforts are implemented at the Service level (i.e., lab, radiology) through the development of performance improvement plans that align with the vision, mission, and strategic goals of the medical center, network, and VHA. Quality councils are established for each service. Specific indicators of both key processes and outcomes of care are designed, measured, and assessed by all appropriate services and disciplines. Key measures of organization performance include those measures required by VA Central Office and accrediting bodies. Measures are objective, measurable, based on current knowledge, and structured to produce valid performance measures of care and service provided. When assessing the performance measures,

opportunities for improvement are identified by comparing against internal performance over time, with external sources of information, and with performance of similar processes in other medical centers. Improvement of functions and processes is accomplished through the FOCUS-PDSA model (figure 6.4).

P.2 c(2) Organizational Learning and Knowledge Sharing – Considerable effort has been made and continues to occur regarding improving the overall operations and the culture of the organization. Major events have occurred which has driven organizational learning and knowledge sharing. In November 2000, a Summit for approximately 50 employees was held. These individuals represented a cross section of organizational levels and occupations throughout the Medical Center. This event initiated a resurgence and dedication of WBVAMC to become the "Best VAMC in Veterans Health Administration". This was a vision expressed by the employees. Three hospital-wide teams were developed as a result of this Summit: "Do Right Culture", Work Processes, and Realign the Organization. This began a movement to change and improve the organization's culture, organizationally realign a number of functions and improve numerous processes. It has lead to the adoption of the Baldrige principles and the endorsement of Stephen Covey's principles. Training on the Covey and Baldrige principles and the literature/reading material associated with them has recharged the organization and more specifically each employee to learn and share ways to improve all aspects of the organization. An organizational focus is maintained regarding performance improvement by including this function as part of the Director's Office. In this way, the organization emphasizes the areas of Patient Advocacy, Risk Management, Patient Safety and Accreditation, and the true principles of performance improvement – that the facility is better today than it was yesterday. The organizational focus is reflected in the deliberations of the PI Steering Committee and at the newly formed Governing Board, where a PI report is given to the facility's management team.

Systematic evaluation and improvement of key processes is addressed at the Service level by conducting Performance Improvement measures reported through the Service meetings and to the appropriate management member. These processes are further reported to Medical Executive Committee, Administrative Leadership Committee, and Governing Board.

Organization learning and knowledge sharing take place at Employee Development Seminars and in all-member Summit and Baldrige meetings. Technical Quality Reviews and Root Cause Analyses are conducted and shared among affected staff as well as Lessons Learned through Performance Improvement and Risk Management efforts.

Key Business Drivers	Strategic Challenges	Operating Strategies	Important Aspect
Quality First	❖ Exceed Performance Standards	**1.1a. (1)** Systematically measure and communicate outcomes and quality of care.	Operational
Easy Access	❖ Improve timely access to care	**2.6.a. (1)** Improve access, convenience and timeliness of VA health care services.	
Enhance Patient Functioning	❖ Aging Population/Long Care Alternatives	**3.9.a. (1)** Enhance outcomes on patients with special needs and special disabilities.	
Exceed Patient Expectations	❖ Improved customer focus	**4.12.a. (1)** Create a health care environment characterized by courteous and coordinated patient-focused services.	
Maximizing Resources	❖ Space Utilization (CARES)	**5.15.a. (1)** Assess and align the health care system to enhance cost effective care for veterans.	Business
Maximizing Resources	❖ Third Party Reimbursements, i.e., (Medicare, Insurance Co.)	**5.15.q. (1)** Increase revenue and efficiency through private sector partnerships, technology and improved business practices.	
Healthy Communities	❖ Community Partnerships	**6.13.a. (1)** Expand federal, state, local & private partnership to faster improvements in coordination and delivery of health care and other services.	

Figure O-11 Strategic Challenges

1.1 Organizational Leadership – 1.1a(1). Senior Leaders Direction - WBVAMC is one of the 163 veterans medical centers nationwide. It is a strong component of an integrated national healthcare system. Leadership principles of the Medical Center are built on the National values as identified in the "Journey for Change". Organizational values are embedded in all Medical Center functions in the delivery of health care to our veterans. A Governing Board and Resource Management Committee have been established and are composed of key multidisciplinary members from top management and major services. These bodies also serve as a means of communicating values to the staff in a variety of ways as illustrated by Figure1.1.

	How Senior Leaders:		
	Set	**Share**	**Deploy**
Values	- Summit Meetings - Strategic Plan - Performance Standards - Governing Board	- Employee Newsletter - Veteran Newsletter - Town Meetings - Performance Based Interviews	- Strategic Planning Committee - Display Mission/ Vision/Value - Performance Based Interviews - Education Department Training Programs - Internet/Intranet Website
Performance Expectations (per Key Business Drivers)	- Balanced Scorecard - Strategic Plan - Nine-Point Financial Plan - Policy Memoranda - Mission/Vision Statements	- Director's Staff Meeting - Employee Staff Meetings - High Performance Development Model - Gallup Survey Results - Town Meetings - Mandatory Review	- Daily Bulletin - Covey Training - Reward & Recognition Policy - Performance Based Interview Process - New Employee Orientation - Internet/Intranet Website
Create Value for Patients/Customers	- Gallup Surveys - Customer Satisfaction Surveys - Policy Memoranda	- Veterans Newsletter - Employee Newsletter - Gallup Survey Results	- Strategic Plan - Covey Training - Performance Based Interview - Reward & Recognition Policy - Internet/Intranet Website
Evaluate Processes	- Strategic Plan - Performance Measures - Gallup Survey - PI Department - VISN Obligation Report - Nine-Point Financial Plan	- Balanced Scorecard - Gallup Survey Results - VISN Obligation Report Statistics Shared at Network Level	- Linkage of Planning and Budgeting - Link Nine-Point Financial Plan to Strategic Plan - Balanced Scorecard - Adoption of "Best Practices"/Benchmarks - Internet/Intranet Website

Figure 1.1 Leadership Roles and Communication Process

The Mission, Vision and Values Statements are communicated throughout the facility. A formal communication plan, which strengthens and formalizes current practices (Figure 1.2) is employed. The Medical Center Director and Senior Leaders personally communicate with stakeholders through a variety of methods such as rounds in patient care areas, informal visits to work areas, continual meetings with staff, periodic union/partnership meetings, and a variety of formal meetings with service organizations, congressionals and suppliers.

1.1a(2). Empowerment, Innovation, Agility and Learning - Senior Leaders committed resources to support a Medical Center summit. This endeavor captured the staff's enthusiasm for change and channeled it into action-oriented outcomes (Figure 2.4).

Covey principles were selected and implemented. The premise was to establish a culture based on a principled approach to teamwork and empowerment. The Baldrige Criteria was selected to produce needed process improvement. Senior Leaders realized that in order to ensure a cultural change, staff had to be supported and encouraged to prosper: 1) Senior leaders actively participated in Covey training and the Baldrige Teams as a self assessment tool to ensure Performance Improvement and Best Practices, 2) Resources, time and money, were dedicated to a Reward and Recognition Program, and 3) Senior Leader guidance was also supplied and communicated throughout the organization. (Figure 1.2).

In support of the changes and the required 40 hours of education for each employee, Senior Leaders allotted the additional funding (Figure 7.3-3). The average cost per employee significantly increased in 2001. In 2002, as a result of a sharp increase in patient workload and a

declining budget, the level of funding for education declined.

COMMUNICATION FLOW								
	Director	Associate Director	Chief Of Staff	Assoc COS/ NE	Service Leaders	Supervisors	Committee Members	Staff
Town Meetings	X	X	X	X	X	X		X
Newsletters	X							X
Meeting Minutes	X	X	X	X	X	X	X	X
Staff Meetings						X		X
Service Meetings					X	X		X
Conference Calls	X	X	X	X	X	X		X
Governing Board	X	X	X	X	X		X	
Medical Executive Committee			X	X	X		X	
Administrative Leadership Committee		X			X		X	
Strategic Planning	X	X	X	X	X		X	
PI Steering Committee			X	X		X	X	X
Director's Staff	X	X	X	X	X	X		
Resource Management	X	X	X	X	X			

Figure 1.2 Communication Flow

1.1a(3). Review Organizational Performance– Senior Leaders have promoted the ONE VA concept thru education. Also, as part of the CARES, collaborative opportunities were explored with Veterans Benefit Administration (VBA) and the National Cemetery Administration (NCA). One of the top priorities of the Secretary of Veterans Affairs is timely resolution of Compensation and Pension claims. We provide exams for the VBA Regional Office in Philadelphia. Members of VBA visit our facility annually to review results of C&P exams with the providers who perform them to ensure a high degree of accuracy and understanding of the process. Timeliness and sufficiency of the exams are monitored through our Balanced Scorecard (figure 1.3)

1.1b(1). Review Organizational Performance - Senior leaders assess organizational performance using a Balanced Scorecard Model (Figure 1.3). This Scorecard is a reflection of those measures considered most critical to the success of the organization and are arrayed in accordance with the Medical Center's Key Business Drivers. Performance according to these measures is assessed on the facility level and the Network level. Facility results are captured on a quarterly basis and are assessed against the results from other VA facilities within the Network, as well as the Network as a whole.

1.1b(2).Prioritizing Opportunities for Improvement - Performance improvement outcomes are utilized by the Strategic Planning Committee and Senior Leaders to assist with the prioritization of strategic planning activities. Identified opportunities for improvement are redirected to the appropriate level for review and recommendation in accordance with our performance improvement process. The process followed is identified in Figure 6.4.

1b(3). Improving Effectiveness – Through our FOCUS-PDSA format (figure 6.4), feedback mechanisms are used to evaluate and improve leadership effectiveness. These mechanisms include employee surveys, focus groups, and town meetings. They provide opportunities for Senior Leaders to obtain employee feedback and clarify strategies, action plans, policies, procedures and results (Figure 1.4). Stakeholder forums such as meetings with Veterans Service Officers (VSOs), congressional briefings and the mini-MAC provide opportunities for patient and stakeholder feedback on leadership performance. The Gallup Q-12 survey is used by Senior Leaders to evaluate employees' engagement and the evolving culture of the WBVAMC. Performance feedback is provided to individual leaders, facilitating changes in approaches to support personal mastery of leadership skills and sharing of best practices with other leaders. Senior leaders also utilize the High Performance Development Model, which incorporates a 360-degree evaluation process.

1.2 Public Responsibility and Citizenship – 1.2a(1). Impact on Society - Meeting expectations of public accountability and responsibility are crucial to the Medical Center's success (figure 0.6). Congress, Veterans Health Administration (VHA), OSHA, FDA, and NRC, set health care delivery standards. Multiple external accreditation bodies, including JCAHO, CAP and CARF, routinely survey our facility, and "mock" surveys are used to prepare for the actual survey. The Medical Center is in compliance with standards set by these accreditation/regulatory bodies.

A formal compliance program is operationalized by the Medical Center's Compliance Committee and reports directly to the Medical Center Director. The Committee's primary purpose is to review facility programs based upon the seven essential elements for hospital compliance.

In an effort to improve patient outcomes, WBVAMC integrated its risk related programs as identified through the Patient Incident Reporting Program, confidential financial disclosure statements, fact-finding/administrative investigations, medical device incident reporting, occurrence screen program, root cause analyses, and tort claims, into a Quality Management/ Performance Improvement Program.

1.2a(2). Anticipating Public Concerns - In an effort to anticipate public concerns and assess potential impacts on our community, we routinely conduct internal and external situational assessments as part of the strategic planning process. These assessments look at the key areas of workload, utilization of services, productivity/ efficiency, demographics, delivery system, managed care penetration, population trends, and market share. We are a key participant in the CARES process. This is a comprehensive, all inclusive analysis of the entire VA system which will determine our gaps between future patient needs and existing capital assets over the next 20 years. We have been proactive in involving our stakeholders and the public in the process, having multiple face-to-face meetings to keep them informed at every step in the process. We routinely obtain customer feedback and concerns through established stakeholders advisory meetings such as VA Voluntary Service and Veterans Service Officer meetings, and stakeholder involvement on the Strategic Planning Committee.

1.2a(3). Ethical Business Practices - The Medical Center ascribes to a strict set of standards of ethical conduct of employees of the executive branch for government. The conduct of our employees is such that they would have no reluctance to make a full public disclosure of their actions. Alleged transgressions from the code of ethics are swiftly investigated and consistent disciplinary action is imposed as warranted.

An Interdisciplinary Compliance Committee is charged with establishing policy and programs to ensure compliance with federal laws, government regulations, and VA policies pertaining to medical necessity, documentation, coding, and billing for services rendered.

Ethical decision-making in patient care issues is guided by generally accepted principles of medical ethics. A Biomedical Ethics Advisory Committee provides consultative services in cases of ethical dilemmas. Employees, patients, family members, and other visitors are invited to consult this committee as the need arises. Posters listing the method to contact the Biomedical Ethics Advisory Committee are prominently displayed throughout the Medical Center, outpatient areas, and satellite clinics. This information is available in the Patient Handbook, which is distributed to each patient upon admission. Leadership encourages and supports sharing our expertise in matters of clinical ethics with the local and national community.

All employees receive education on the standards of ethical conduct and medical ethics as part of their initial orientation and annual mandatory education. Topics such as conflict of interest, conduct, advance directives, informed consent, and patients' rights are covered. The number of employees who received mandatory annual training is shown in Figure 7.4-11. Employees who are involved in contracting, purchasing, approving or recommending purchases or contracts are mandated to receive additional intense training on ethical conduct and business practices yearly.

VAMC WILKES-BARRE BALANCED SCORECARD

					Fiscal Year 2003			
	FY01	FY 02	Fy-03 Target-Fully Successful	FY-03 Target - Exceptional	FY03 Qtr 1	FY03 Qtr 2	FY03 Qtr 3	FY03 Qtr 4
1. PLACING QUALITY FIRST								
a. Prevention Index (PI)								
(1). Ambulatory Care								
(a). Hepatitis C Screened for Risk Factors		100%	91%	95%	100%			
(b). Hepatitis C w/ Positive Risk Factors has Confirmatory Tests		62%	82%	87%	100%			
(c). Colorectal Cancer Screening		71%	70%	75%	63%			
(2). Geriatrics and Extended Care MDS-QIR			TBD	TBD				
(3). Mental Health								
(a). Hepatitis C Screened for Risk Factors		97%	91%	95%	100%			
(b). Hepatitis C w/ Positive Risk Factors has Confirmatory Tests		85%	82%	87%	100%			
b. Clinical Practice Guidelines								
(1). Ischemic Heart Disease		Quadrant I	**Quadrant II or IV**	Quadrant I	Quadrant I			
(a). Apirin at Most Recent Outpatient Visit	74%	91%	93%	95%	88%			
(b). Beta Blocker at Most Recent Outpatient Visit	81%	85%	84%	89%	100%			
(c). LDL-C < 120		82%	71%	74%	78%			
(2). Diabetes Mellitus		Quadrant I	**Quadrant II or IV**	Quadrant I	Quadrant I			
(a). Retinal Exam	70%	73%	77%	82%	63%			
(b). HgbA1c<9	81%	83%	81%	83%	89%			
(c). HgbA1c>11 or not done	12%	7%	9%	8%	4%			
(d). BP < 140/90	46%	61%	71%	74%	78%			
(e). BP greater than or equal to 160/100	21%	14%	10%	8%	4%			
(3). Major Depressive Disorder		Quadrant I	**Quadrant II or IV**	Quadrant I	Quadrant I			
(a). Screened for MDD	93%	95%	92%	97%	92%			
(b). F-U assessment or Referral for Patients w/ a Positive MDD Screen	63%	80%	70%	80%	*			
(4). Hypertension		Quadrant I	#	#	#			
(a). HTN and BP <140/90	46%	60%	66%	68%	79%			
(b). HTN and BP greater than or equal to 160/100	20%	12%	10%	8%	4%			
(5). Congestive Heart Failure		Quadrant I	#	#	#			
(a). Patients Discharged with Primary Diagnosis of CHF Received Diet/Weight/Meds/Follow-Up instructions @ Discharge.	5%	69%	70%	85%	78%			
(6). Tobacco Use		Quadrant I	**Quadrant II or IV**	Quadrant I	Quadrant I			
(a). Tobacco Counseling - Primary Care	62%	80%	75%	85%	71%			
(b). Tobacco Counseling - Mental Health		74%	75%	85%	67%			
(c). Tobacco Screening - Primary Care	97%	99%	96%	98%	100%			
(d). Tobacco Screening - Mental Health		98%	96%	98%	100%			
2. EASY ACCESS TO CARE								
a. Clinic Waiting Times		All clinics = or < 30 days		Meet targets for all speciality clinics				
(1). Audiology	13 days	2 days	< 41 Days		33			
(2). Cardiology	47 days	28.3 days	< 43 Days		38			
(3). Primary Care/Med	67 days	18.1 days	30 Days		36			
(4). Eye Care	92 days	38 days	< 64 Days		45			
(5). Orthopedics	32 days	14 days	< 44 Days		12			
(6). Urology	57 days	4 days	< 45 Days		34			
b. Number of Vested Patients (Basic + Complex)								
3. ENHANCE, PRESERVE, & RESTORE PATIENT FUNCTION								
Homeless - Percent of veterans discharged from Domiciliary Care or Health Care for Homeless Veterans (HCHV) community-based contract residential care program to independent living or a secure institutional arrangement will increase.		80%	65%	78%	57%			
4. EXCEED PATIENT EXPECTATIONS								
a. Veteran Satisfaction (SHEP) - Ambulatory Care			70%	72%	2nd qtr			
b. Veteran Satisfaction (SHEP) - Inpatient			68%	70%	2nd qtr			
c. Employer of Choice - Results of employee satisfaction survey evaluated for OFI's and facility action plan developed by 3/1/2002.	Qualifying Measure: Yes or No		Achieve	Milestone	2nd qtr			
d. C&P Average Processing Time	39 days	29 days	35	26	31			
e. Sufficient C&P Exams	100%	100%		100%	99%			
5. MAXIMIZE RESOURCES								
a. % Obligations to Current Budget (based on yearly obligation)		102.5%	100% + 0.9%	<100%	100%			
b. % MCCF Goal (based on yearly estimated collections to date)		133%	>98%	>100%	82.9%			
6. BUILD HEALTHY COMMUNITIES								
Increase medical residents' and other trainees' scores on a VHA survey assessing their clinical training experience.	74%	80%	70%	N/A	4TH qtr			

Red = Not Met Black = Fully Successful Green = Exceptional

*** Sample size too small (under 30)**

 # Included with Ischemia Heart Disease for FY-03

Figure 1.3 Balanced Scorecard

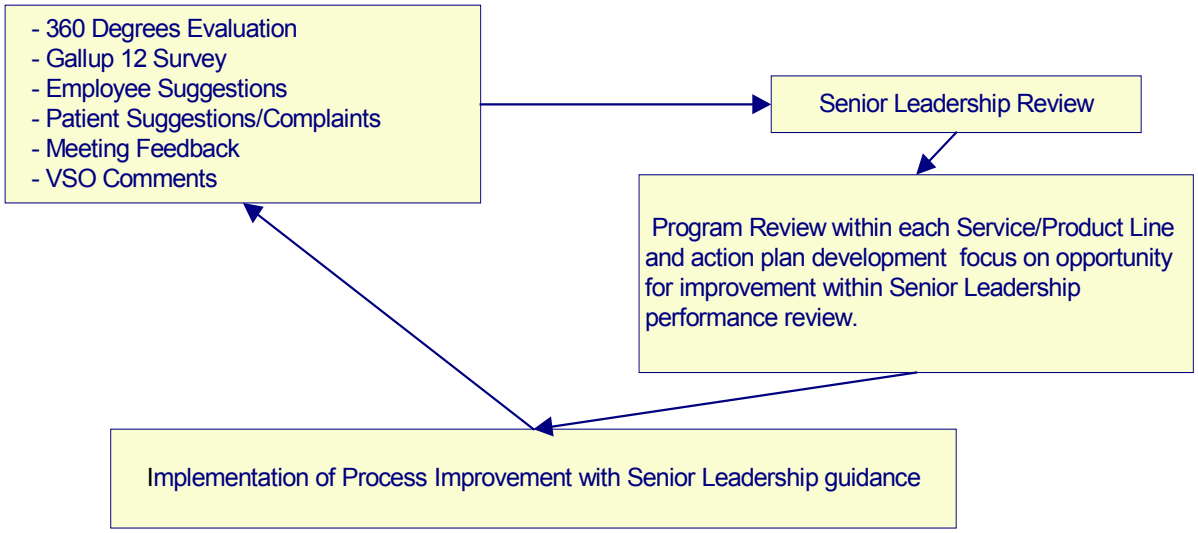


Figure 1.4 Improving Performance thru Feedback

1.2b.Support of Key Communities and Community Health – WBVAMC was founded with the generous support of the Northeastern Pennsylvania community. This spirit of community support continues today with the Medical Center's service to the community. We have partnered with community healthcare and social service agencies in developing a comprehensive healthcare needs assessment to identify unmet veteran needs in our service area (Figure 1.5).

Community Issue	Activity	Outcomes
Homeless	Stand Down	Health screenings
	Fr. Nolan Residence	8-bed housing unit in conjunction w/ Commission on Economic Opportunity
	Dental Services	Dental Care for Veterans in Rehabilitation Programs
	Community-Based Rehabilitation Services	Sponsor 4 "half-way" houses, case management, counseling, job placement and transitional housing
	Halfway House	There were 11 veterans admitted in FY-02
Access to Care	Marketing Studies	Expanded Williamsport added Berwick
	Stragetic Planning	
Physician Services	Fully Accredited Medical Residency Program	Over 300 physicians graduated, with more than 30 practicing in the local community
Unmet Healthcare Needs	Flu Clinics	Conducted numerous flu screenings providing approximately 15,000 doses
Emergency Preparedness	Emergency Drills	Serve as a resource for community emergencies (e.g., care for nursing home patients displaced due to a fire)
Law Enforcement	K-9 Unit	Medical Center Police trained canines who are used on an average of 52 times per year to assist community with tracking missing persons, bomb detection and narcotic searches
Charities	Combined Federal Campaign	Annual increases in employee contributions and fund raising activities (Figure 7.58).
	Adopt-A-Family Basket Project	Employees provided food, clothing, toys, and gift certificates to 58 veterans and their families (a total of 89 individuals).
	Red Cross Blood Drives	Employees donate blood on a quarterly basis (Figure 7.59).
Leadership Team Involvement	Chief Operating Officer	Member, Building and Grounds Committee of Holy Family Church
	Chief of Staff	Consultant to Dallas Religious Consultation Center
	Associate Chief of Staff of Operations/Nurse Executive	Member of Nursing Advisory Boards: College Misericordia; Marywood University; and University of Scranton
		Chairperson, Northeast PA Collaborative Nursing Council

Figure 1.5 Community Support

2.1 Strategy Development – 2.1a(1). Strategic Planning Process - The Strategic Planning Committee (Figure 2.1) is comprised of representatives from all areas of the Medical Center, technical advisors, and stakeholder representatives. It is responsible for defining the organization's Mission, Vision, and Values and for engaging in the strategic planning process. The Committee develops, monitors, and analyzes system-wide strategic and operational plans for the Medical Center and establishes priorities for short-term and long-term decisions involving health care initiatives and capital investments.

The Strategic Planning Committee develops the annual Strategic Plan and submits it to the Governing Board and to the Director for approval.

The Strategic Planning process (Figure 2.2) captures the Medical Center Director's Performance Plan and the Nine-Point Financial Plan and is in direct alignment with the Network 4's Strategic Plan. The planning horizon is five years with a detailed plan developed for one year.

Strategic Planning Committee

Chairperson: Staff Assistant to Director, Wilkes-Barre VAMC

Members:

Associate Chief of Staff for Clinical Services/ Nurse Executive	Chief, ICU/CCU, Primary Care & Medical Service
Chief Financial Officer	Chief Medical Officer, SOPC
Chief, Business Office	Chief, Acquisition & Materiel Management
Associate Chief, Primary Care & Medical Services & Behavioral Services	Minority Veterans Program Coordinator
JCAHO Coordinator/PI Coordinator	Women Veterans Coordinator
Associate Chief, Rehabilitation & Prosthetics Service	Voluntary Service Specialist
	President, AFGE Local #1699
	Stakeholder Representatives (3)

Figure 2.1 Strategic Planning Committee Members

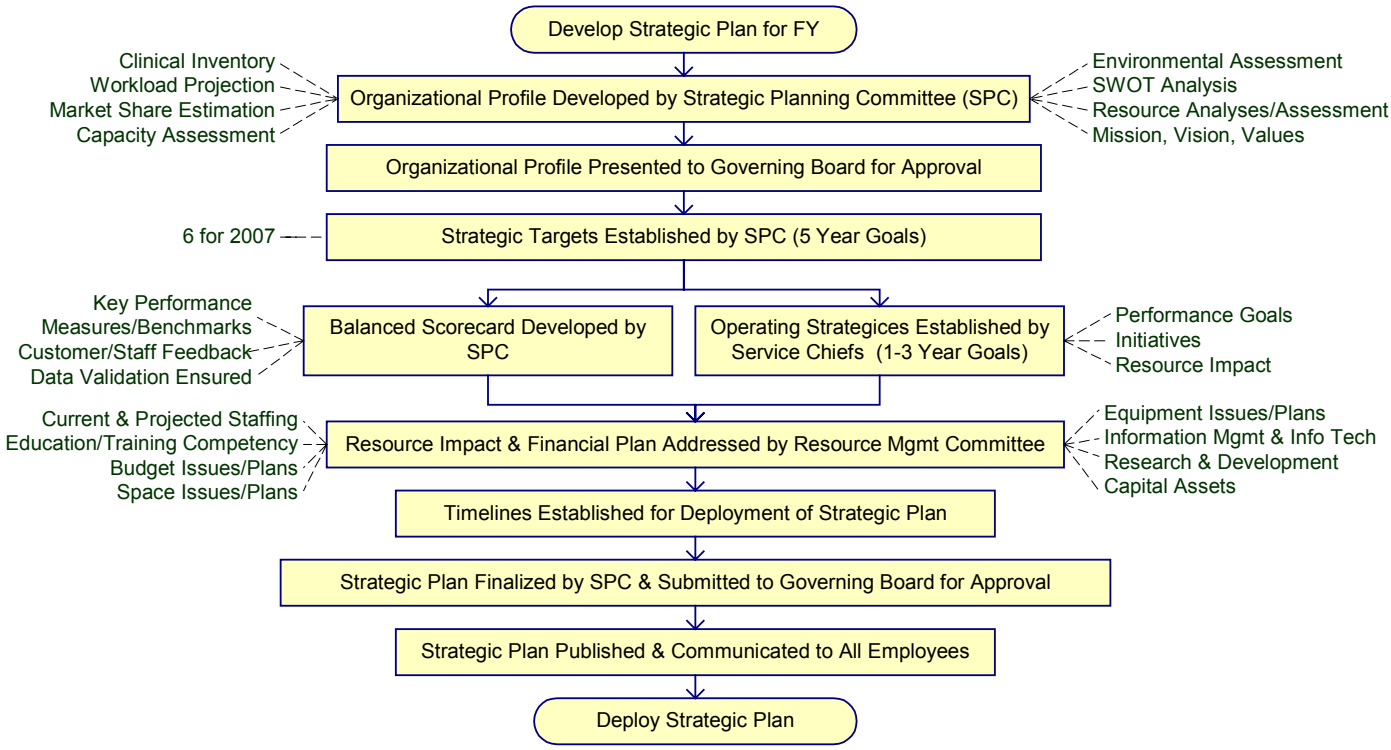


Figure 2.2 Strategic Planning Process

2.1a(2). Planning Factors - Information and data are obtained from a wide variety of sources and utilized in the planning process at the WBVAMC (Figure 2.3).

2.1b(1). Strategic Objectives and Timetable - WBVAMC links its strategic objectives and key measures with VHA's 6 for 2007 Goals. The goal achievement status is monitored on a continuing basis and reported at major committee meetings. The facility's Balanced Scorecard communicates the progress on the goal attainment to all employees, and stakeholders (Figure 1.3). Analysis of the data and information acquired during the review of the goal achievement progress reveals opportunities for improvement to more fully achieve our mission. Figure 2.4 demonstrates the Medical Center's Strategic Objectives and their linkages to our Key Business Drivers (6 for 2007 Goals) and key measures, as well as targeted achievement levels. WBVAMC goal achievement results for Fiscal Years 2000, 2001 and 2002 in comparison to target levels, and in comparison to Network results are shown in Figures 7.1-2, 7.1-3, 7.1-6, 7.1-7, 7.1-10, 7.4-1, 7.4-2, 7.4-3, 7.4-4, 7.4-5, and 7.4-11.

2.1b(2). Objectives vs. Challenges and Patient Needs –WBVAMC strategic objectives were developed in

accordance with VHA's 6 for 2007. Senior Leaders, Governing Board, Strategic Planning Committee, Medical Executive Committee, Administrative Leadership Council and Performance Improvement processes ensure that the strategic objectives balance the needs of patients and other key customers and stakeholders. Monitoring is done on a monthly basis to ensure the continuity of results and to sustain improvement (Figure 2.4).

2.2 Strategy Deployment - 2.2a(1). Develop and Deploy Action Plans – The development of the WBVAMC's action plans are based on an active, learning process. Input is obtained from employees at all levels of the organization with the cornerstone being the Mission, Vision, and Values. The plan is developed annually by considering the key short and long-range action plans based on identified strategic targets, operating strategies, and performance goals (Figure 2.5).

Key Factors	Information Obtained	How Analyzed	How Information is Used in Planning	Key Staff Responsible for Inclusion
Customer and Market Needs and Expectations	▪ Enrollment and market share ▪ Customer Satisfaction Surveys – national & local ▪ Historical patient data ▪ Inpatient & outpatient models ▪ Hospital/VISN 4 database ▪ Veterans groups ▪ Patient advocate reports ▪ CEO's town meetings ▪ Situational Assessment ▪ CARES	▪ VISN & facility build graphs ▪ Compare w/ current and past data ▪ Performance Improvement ▪ Aging population	▪ Reviewed project future needs ▪ Define Strategic Assumptions ▪ Set Medical Center targets ▪ Set performance goals ▪ Need for new service	▪ Planner ▪ Patient Representative ▪ Clinical Service Chiefs ▪ Business Office ▪ Leadership Team ▪ Governing Board ▪ Resource Management Com
Competitive Environment/Capabilities	▪ Research National Database ▪ Clinical Inventory ▪ DSS Data ▪ Cost/Benefit Analysis ▪ Best Practices ▪ Balanced Scorecard ▪ Situational Assessment ▪ Benchmark Organizations	▪ Compare data against VISN Goals and Targets ▪ Capacity of community providers	▪ Continuous process improvement ▪ Redefine goals and targets	▪ Strategic Planning Committee ▪ Leadership Team ▪ Contracting Officer ▪ Governing Board ▪ Resource Management Com
New Technologies & Key Changes	▪ Inventory of technology ▪ Situational Assessment	▪ Situational Assessment ▪ Comparative data ▪ Technology/equipment Review	▪ Budget Plan ▪ Equipment/technology purchase ▪ Space design	▪ Clinical Service Chiefs ▪ Leadership Team ▪ Information Officer ▪ Bio-medical Engineer ▪ Contracting officer ▪ Governing Board ▪ Resource Management Com
Strengths& Weaknesses – Resources	▪ Recruitment & retention data ▪ Staff education measure results ▪ Employee learning needs assessment	▪ Reviewed by HR Committee, & Strategic Panning Committee	▪ Develop HR plan ▪ Develop Strategic Plan ▪ Career Development ▪ Succession Planning	▪ CFO ▪ HR Committee ▪ Planner ▪ Leadership Team ▪ Governing Board ▪ Resource Management Com
Supplier/Partner Strengths & Weaknesses	▪ Situational Assessment ▪ Face-to Face meetings ▪ Surveys ▪ Review of contracts	▪ Potential for partnerships ▪ Status of performance goals ▪ Cost-benefit analysis	▪ To continue contract ▪ Revise affiliation agreements	▪ Contracting Officer ▪ Information Officer ▪ Planner ▪ Affiliates ▪ Leadership Team ▪ Union ▪ Governing Board ▪ Resource Management Com
Financial, Societal, Regulatory Risks	▪ Budgeting data/VOR ▪ Balanced Scorecard ▪ JCAHO scores	▪ Comparative Data ▪ Benchmark Data	▪ Service needs policy changes ▪ Expand services ▪ Maintain services	▪ CFO ▪ Planner ▪ HR Committee ▪ Contracting, Information, & Compliance Officers ▪ Leadership Team ▪ Governing Board ▪ Resource Management Com

Figure 2.3 Key Sources for Strategic Planning

WBVAMC performance measures include the related key business drivers, strategic objectives/ strategies, data source, numerator, denominator and issue outcomes. Progress on the established strategic targets and performance measures is reported quarterly at appropriate committees and workgroup meetings. All of the performance measures are linked to important JCAHO Functions, dimensions of

performance, key business drivers and VHA mandated monitors. WBVAMC utilizes the Balanced Scorecard (Figure 1.3) to measure the efficiency and effectiveness of the facility over time. Services/Program officials develop action plans (Figure 2.6) to accomplish the action within the fiscal year. The responsible parties, electronically via the server, provide monthly updates. The results are complied and shared at each monthly Governing Board meeting.

2.2.a(2). Key Short & Long Term Action Plans – The Medical Center's key short-term and long-term action plans are contained in the strategic plan. They are aligned with VHA's 6 for 2007 planning framework and the Medical Center Director's Performance Plan (Figure 2.4).

The Balanced Scorecard (Figure 1.3) delineates specific measures in accordance with our Key Business Drivers. Furthermore, our identified challenges (Figure O-11) are linked with our strategic objectives, which are aligned with our key measures (Figure 2.4). Additional action plans are developed by our Cores/departments, which supplement the achievement of the facility's strategies.

2.2.a(3). Key Human Resource Plan – In developing action plans for the accomplishment of the Strategic Plan, resources including human resource needs, are identified. A separate section within the plan identifies the staffing needs/priority for the fiscal year. This plan is used to guide the decision-making process of the Resource Management Committee.

2.2a(4). Key Performance Measures – The Director receives performance measures and strategic planning guidelines, as well as a performance contract. These elements of the contract are incorporated into the strategic plan. Information for salient measures is rolled up into the facility Balanced Scorecard (Figures 1.3 and 2.4).

2.2(b). Performance Projections – Key performance projections are noted in Figure 1.3 and 2.4. Projections are identified by reviewing results of competitors, other facilities within the Network, and past performance

Key Business Drivers	Strategic Objectives/ Strategies	Key Measures	Link to Strategic Challenges	2001 Results	2002 Results	2003 Results (Current)
1. Placing Quality First	**1.1.a (1)** Systematically measures and communicate the outcomes and quality of care.	Ischemic Heart Disease	Exceed performance standards	Quad II	Quad I	Quad I
2. Easy Access to Care	**2.6.a (1)** Improve access, convenience and timeliness of VA health care services	Waiting Times for Appointments - Audiology - Cardiology - Ophthalmology - Orthopedics - Primary Care - Urology	Providing timely access to care	 13 47 92 32 67 57	 2.0 28.3 38.0 14 18.1 4	 33 38 45 12 36 34
3. Enhance, Preserve & Restore Patient Function	**3.9.a (1)** Enhance outcomes for patients with special needs and special disabilities	% vets discharged from Homeless Program to independent living	Aging Population/Long Term Care Alternatives	N/A	80%	57%
4. Exceed Patient Expectations	**4.12.a (1)** Create a health care environment characterized by courteous and coordinated patient-focused services	C&P Average Processing Time	Improve customer focus	39	29	31
5. Maximize Resources	**5.15.a (1)** Assess and align the health care system to enhance cost-effective care for veterans	% MCCF Goal	Third Party Reimbursement	N/A	133%	82.9%
6. Build Healthy Communities	**6.19.** Develop new state of the art training programs to best educate the health care professionals of the future	Increase medical residents and other trainees scores on VHA survey assessing their clinical training experience.	Community Partnership	74%	80%	4th Qtr

Figure 2.4 Key Performance Indicators Red = Not Met Yellow = Fully Successful Green = Exceptional

- FY 02 Outcomes
- Mission/Vision/Values
- Organizational Profile
- Scope of Service/Clinical Inventory
- SWOT Assessment/Reassessment
- FY03 Budget Execution Assumptions
- Strategic Objectives
- Balanced Scorecard (Performance
- Resources: Staffing, Budget, Space, Equipment Needs

Figure 2. 5 Elements of Strategic Plan

Key Business Driver: **2** - Provide easy access to medical knowledge, expertise, and care.
Strategic Objective: **2.1** – Increase the percentage of all non-emergent primary care appointments scheduled within 30 days of desired date.
Goal: Improve access, convenience, and timeliness of VA health care services.
Actions: **a)** Introduce the enhanced access program to the Primary Care areas in an effort to overcome challenges reflected through the increased number of unique patients.
b) Recruit 2.0 FTEE physicians for projected increase of 2,500 patients over existing 38,000
c) Reassign 1.0 FTEE RN/LPN from inpatient areas.
Responsible Party: **a)** Chief of Staff
b) Chief, Primary Care & Medical Services
Target Date: 11/01/02

Figure 2.6 Example of Action Plan

3.1 Patient/Customer and Health Care Market Knowledge -3.1a(1) Customer and Market Knowledge – WBVAMC provides healthcare services to all enrolled veterans in portions of Pennsylvania, New Jersey and New York. Congress mandates eligibility criteria for veterans, our primary customers, through federal legislation. This legislation defines our general mission, and explains our benefits and eligibility requirements. Once eligibility is established, the veteran is enrolled and placed in the appropriate category/priority group. Each category/priority group determines the veterans' special care service eligibility, and co-pay/exemption status. The segmented customer plan for veterans falls into eight category/priority groups.

We segment all our key customers by using demographic information from local sources and the Survey of Healthcare Experiences of Patients (SHEP)(Figures 7.1-4 and 7.1-5). All of our key customers are categorized into customer segments which include: Primary Care, Acute Care, Long Term care, Behavioral Health Care, and Specialty Care.

Other customer groups we serve include: federal/state/local governments, and elected public officials, veterans' service organizations, volunteers, academic affiliates, private agencies, third party payers, healthcare providers, media, Champ VA / Tri-care beneficiaries, and contractual agencies.

3.1.a (2) Listen and Learn to Determine Customer Requirements – A variety of strategies (Figure 3.1) are used to listen and learn about customer needs. This information is gathered by methods which include surveys, patient advocate compliments/complaints, direct input from patients, congressional/central office correspondence, stakeholder feedback, Veteran Service Officers meetings, mini-Management Advisory Council (MAC), Veterans Affairs Voluntary Services (VAVS) (Figure 7.4-15) and community input.

Each listening and learning strategy occurs at least on an annual basis through our national customer Survey of the Healthcare Experiences of Patients (SHEP) report. This survey reflects both inpatient and outpatient survey results. Our Patient Advocate prepares a provider specific/area specific report, meets with and presents this report to the chief of each service on a monthly basis. Appropriate action is taken by the service chief and reported back to the Patient Advocate, Office of Quality Performance.

Feedback is gathered through surveys, focus groups, interviews/meetings, Voluntary Service Organization officers, etc. This information is then passed along to our Governing Board, Leadership Team and the Strategic Planning Committee.

3.1a(3) Current Listening/Learning Methods – Listening and learning strategies are kept current by creating a continual learning environment where the needs of our veterans are easily extracted by methods noted in 3.1a(2). Continued personal contact and maintaining an open system, conducting customer focused training programs, tracking innovative and effective services and utilizing/ applying lessons learned from critical incidents.

A systematic approach to ensure effective listening by our Senior Leaders is evidenced by continually reviewing how to improve our listening methods and

learning the needs of our veteran/patients and implementing services where the need has been identified. This resulted in a 24/7 Telephone Triage is in place via a contract with the Bronx VAMC. A monthly report delineating the volume and types of calls received is provided to the Leadership Team.

Customer Segment	Need	Listening and Learning Strategies	Mechanism for Deployment	Learned Customer Requirements
All Veterans	Improved Access: Single Provider of Care: Shorter Waiting Times	Customer surveys; Patient Advocate feedback; National performance initiatives; Veteran focus groups; Newsletters; Websites; Toll-Free Number	Primary Care Model	Patient Care Teams; New and/or expanded outpatient clinics; Transportation systems
Women Veterans	Privacy: Preventive health care and maintenance: Early Detection and treatment of cancer: OB/GYN care	Customer surveys; Patient Advocate feedback; National performance initiatives; Veteran focus groups; Newsletters; Websites; Toll-Free Number	Women Veteran Coordinator	Environment changes to address privacy; Contract for OB/GYN services
Geriatric Veterans	Improved access: Single provider of care: Alternative to Institutional Care (Home Care, ADHC)	Customer surveys; Patient Advocate feedback; National performance initiatives; Veteran focus groups; Newsletters; Websites; Toll-Free Number	Interdisciplinary Committee	Contract for Home Health Care; Established primary care in long term care setting; Contracts for alternatives to Long Term Care (Respite)
Volunteers	Communication; involvement in planning process	VAVS meetings; Customer Relations Service feedback; Suggestion program	VAVS Committees; Management Assistance Council	Increased communication and sharing of information
Veteran Service Organizations	Communication; involvement in planning process	VAVS & VSO monthly liaison meetings; State and National veteran meetings; numerous volunteer events	VAVS monthly meetings; Mini-Management Assistance Council	Veterans included in membership of Mini-Management Assistance Council; Open flow of newsletter information is critical
Congressional	Communication; involvement in planning process	Congressional meetings; Congressional letters	Mini-Management Assistance Council; Congressional meetings; Phone conversations and written correspondence	Increased communication and sharing of information

Figure 3.1 Needs of Key Customers

3.2 Patient/Customer Relationships and Satisfaction - 3.2a(1 & 2) Customer Relations - Relationships are fostered with veterans/customers through each veteran/customer contact. Through personal encounters we identify individualized needs and service requirements leading to performance improvement.

Access to services provided by the Medical Center is available through different modes. Contact mechanisms include the use of the telephone (e.g., 24/7 Telephone Triage, Toll-Free Number, daily phone contacts), newsletters, written correspondences, Internet Routing and Information System (IRIS), surveys, focus groups and Patient Advocate initiatives/feedback. Information/ data received from these mechanisms is shared with a variety of sources, i.e., sources that have a direct interest in customer issues (Figure 3.2).

Contacts are specific for customer segments; e.g., partnerships with community agencies to provide residences for the homeless and programs offering health and non-health related services (job opportunities, housing, etc.) have been jointly held with community agencies.

The National Patient Data Feedback Center Survey (intranet) provides drill down information from patient satisfaction results for strategizing and focusing on improvement efforts. The patient satisfaction surveys measure performance on as many as eleven different Veterans Health Care Services. The site provides National, Network, Facility, Clinic and CBOC level data, at the standard and question level, as well as response category counts and percentages, and demographic information. The data, collected and reported through the sources (figure 3.2), is analyzed by Leadership and our Strategic Planning Committee and is used to make decisions concerning increasing repeat business through customer satisfaction.

3.2a(3) Complaint Management Process - WBVAMC Patient Advocacy program functions whereby complaints are identified, resolved, classified, reported and utilized to improve overall service to the veterans we serve (Figure 3.3). All employees are encouraged to act as advocates and resolve patient complaints at the

lowest level possible, referring to the facility's patient advocate when this is not possible. Reported results are used to compare this patient data with Customer Service Standards and to develop Medical Center action plans.

Source	Type of Data – Interface	Frequency
U.S. Congress	Health care requirements and priorities for veterans, regulations, standards	Ongoing
VA National Health Survey of Veterans	Health Status Survey	Annual
Affiliations	VA's mission to provide medical and other professional health care education	Ongoing
National, State and Local Veterans Service Organizations	Interface at all levels of the organization to assess and address the needs of our veterans	Ongoing
Veterans Day Ceremonies	Recognition and visibility event	Annual
National Salute to Veterans	Public recognition of our veterans	Annual
National Veterans Wheelchair Games	Co-sponsored by VA and the Paralyzed Veterans of America and Corporate sponsors.	Annual

Figure 3.2 Interfaces With Key Stakeholders

3.2(a)(4) Keeping Customers' Access/ Relationships Current–WBVAMC has established, and used when necessary, outreach and enrollment strategies to build and sustain healthy relationships (Figure 3.4. Through our customer service programs, we re-evaluate approaches to ensure easy access and relationship building to keep current with customer requirements, technology, and organizational direction.

3.2 (b)(1) Customer Satisfaction/Dissatisfaction – Satisfaction is determined by the administration of standardized survey instruments (Figure 3.5). Different surveys are administered to specific veteran populations.

The survey questions are linked to the Veterans Service Standards (Access, Courtesy, Preferences, Emotional Support, Education Needs, and Coordination of Care, etc.). A Prosthetics Survey measures patient satisfaction with prosthetic services. Home Based Program Care and Spinal Cord Injury Surveys included additional questions unique to their needs, National, Network, facility, and clinic survey results are entered on the National Patient Data Feedback Center website (Figures 7.1-5, 7.1-6, 7.1-7, 7.1-10, and 7.1-11). This allows drilling down to the standard and question level as well as response category counts and percents, and categorized by facility. Customer satisfaction surveys have been used to achieve more timely results (Figures 7.1-5, 7.1-6, 7.1-7, 7.1-10, and 7.1-11). Some additional facility/local surveys used include Homeless Veteran Program and Compensated Work Therapy/Veterans Industry Program (Figures 7.2-11 and 7.2-12).

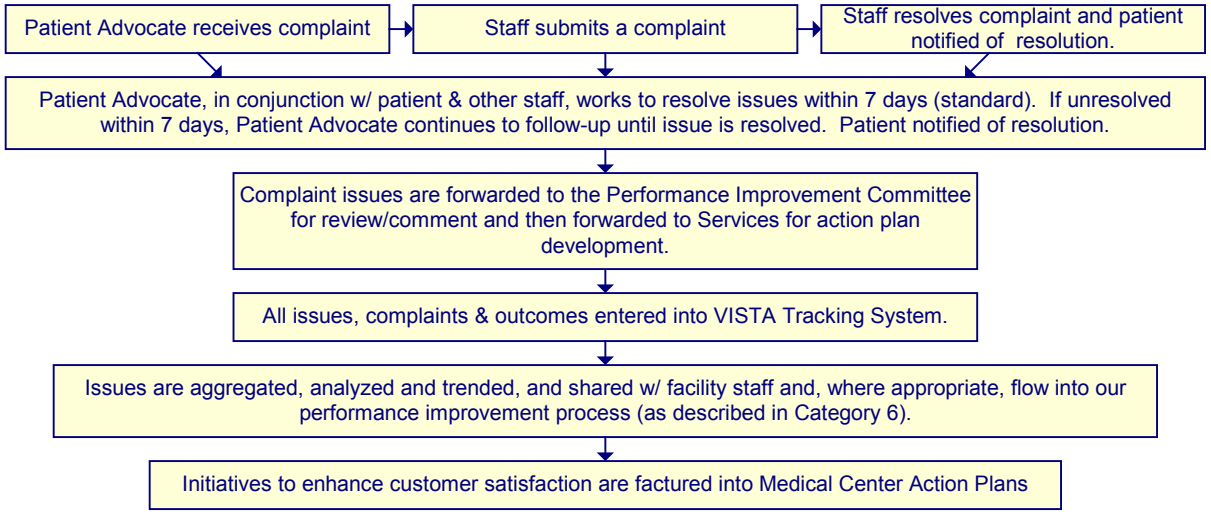


Figure 3.3 Patient Advocacy

Marketing Activity	Examples
Fairs	Enrollment Fairs, Regional, County, Pennsylvania Health Fairs
Speakers Bureau	Professional Staff Presentation to school, community support groups, professional groups, colleagues, VSO, VFWs
Reports/Newsletters	Veterans First Newsletter, Network Comprehensive Health Care Brochure mailed to all patients
Surveys/Contacts with Patients	Marketing survey targeted at non-users
Technology	Use of a 24/7 Telephone Triage

Figure 3.4 Outreach Strategies

Population	Years Surveyed	Population Sample	Frequency
Outpatient	1995, 1996, 1997, 1998, 1999, 2000,2001	175 patients in each of 600 outpatient clinics	Semi-annual
Inpatient	1995, 1996, 1997, 1998, 1999, 2000,2001	Patients discharged from acute care VAMC (Neurology, Rehab. Medicine, Surgery, Psychiatry, & SCI)	Annual
Spinal Cord Injury (SCI)	1997, 1998, 1999, 2000,2001	175 patients from each 23 SCI Centers/136 from each non-SCI Center	Annual

Figure 3.5 Satisfaction Instruments

The WBVAMC received the first results derived from The Survey of Healthcare Experiences of Patients (SHEP) in October of 2002 (Figures 7.1-1, 7.1-2, 7.1-3, and 7.1-4). Results were reported to the Performance Improvement Steering Committee for Action Plan development. Four categories needed immediate attention: Pharmacy Pickup, Overall Coordination of care, Education/ Information and Emotional Support. An action plan identified 21 initiatives and the aggressive dates for implementation were within the range of immediate to two months. Only two outstanding initiatives remain with a target date of March 2003 for completion.

3.2(b)(2) Follow-Up and Feedback - One of our Key Business Drivers is "Exceed Patient Expectations." Results from two indicators measuring this driver (C&P Average Processing Time and Sufficient C&P Exams) have reflected our ability to be responsive to patient needs. Data on these measures (Figures 7.1-12 and 7.1-13) provide feedback to determine whether patient needs are met. Data from the surveys are used to identify problems along with information from other feedback (Figure 3.6). Action plans are developed in our strategic plan to address identified problems.

3.2(b)(3) Satisfaction and Benchmarks – The Veteran Satisfaction Surveys use the Picker Institute patient satisfaction data as a benchmark. Picker surveys are designed to assess patients' experiences within dimensions of care that patients' value most (Figure 3.7). In addition, we examine VHA and national surveys for comparative data that assist with target setting and improving health care for our veterans. From a recent patient satisfaction survey, continuity of care was an issue. To address this, we recently implemented a case management approach for inpatients to assure that inpatients are transitioned to the appropriate level of care. Since comparison with competitors applies to all VHA healthcare facilities, we benchmark against our own best practices to achieve world- class performance in a cost effective manner.

3.2(b)(4) Satisfaction and Business Needs - WBVAMC utilizes state of the art reports to determine satisfaction with healthcare services: Picker Institute Satisfaction Scores, National Customer Satisfaction Surveys, Survey of the Healthcare Experiences of Patients, local medical center surveys, and Patient Advocate Reports. Open communication is also derived from continuous meetings of Mini-Management Assistance Councils, Veteran Service Organizations and, VA Voluntary Service meetings, and our newest method being the Penn - Centra 200, a hand held computer device that is used to survey patients immediately after their visit to the Medical Center.

4.1 Measurement and Analysis of Organization Performances - 4.1a(1) Performance Measurement - Clinical, financial, and operational measures utilize data to support. measures aligned with VHA's 6 for 2007, the Network Performance Plan and the facility's Key Business Drivers and Strategic Plan.

A well-defined process is in place where information is gathered and integrated by our Business Office. Data is made available to Senior Leaders and to all of the clinical and administrative services through the Performance Improvement Committee, Medical Executive Committee, the Administrative Leadership Council, and the Governing Board in 2003. Data is collected consistently across the organization, at regular intervals, most of which is posted on our website. This data is used by numerous committees and services to review and assess their performance, identify gaps and identify opportunities for improvement.

Operating Strategies	Action Plans
4.11.a. (1) Ensure that patients understand and participate in decisions about their health care.	(a) Ensure that performance reaches the fully satisfactory level on exceeding patients' expectations.
4.12.a. (1) Create a health care environment characterized by courteous and coordinated patient-focused services.	(a) Realize a customer-friendly, patient focused environment by June 2003 through the use of improved signage, and continued educational initiatives. (b) Identify staff through use of uniforms and badges and purchase replacement uniforms. (c) Reduce window-waiting times by restructuring processes. Use CMOP to facilitate reduction of waiting times at pharmacy windows. (d) Reduce number of patient service problems as reported in the National Performance Data Feedback Center outpatient survey in all components.
4.13.a. (1) Continually assess and improve patients' perceptions of their VA health care.	(a) Assess the feasibility of developing service level patient advocate program. (b) Initiate the PULSE Toolkit. (c) Utilize Women Veterans' Coordinator to address women's issues in the community. (d) Report results of National Customer Feedback Surveys for inpatient care, outpatient care, HBPC and the special emphasis programs to customers and veteran service organizations. (e) Utilize Minority Veteran Coordinator to address minority issues in community and at medical center.

Figure 3.6 Improvement Strategies

Dimensions of Care	Picker Institute	Veteran Service Standards
Access to Care	X	X
Respect for patients' values,	X	X
Coordination of Care	X	X
Information and education	X	X
Physical comfort	X	X
Emotional support	X	X
Involvement of family	X	X
Transition and continuity	X	X

Figure 3.7 Satisfaction Comparisons

4.1a(2) Aligning Measures - A national system of performance measures is established by VHA and is implemented at WBVAMC. These well-delineated measures are based on our six Key Business Drivers (6 for 2007). Each driver then relates to goals with quantified objectives. Our Strategic Plan outlines goals in alignment with VHA's and the Network's mission, as well as the Network's and our Balanced Scorecard. Veteran and staff satisfaction are compared to external benchmarks. Our measures include metrics to track all of our key processes. The Performance Improvement Committee monitors performance in these areas and reports results to the Governing Board which conveys the information to the appropriate administrative and clinical services.

4.1a(3) Use of Data/Information - Facility performance is measured through the use of competitive comparisons from National, Network, and facility levels and, as available, community benchmarking data. A logical, sequential process is used when conducting these comparative analyses (Figure 4.1).

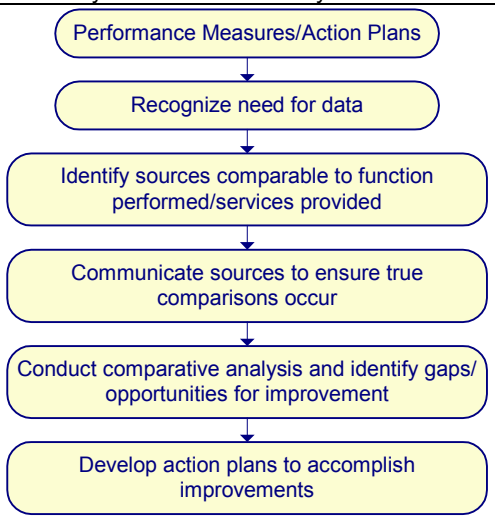


Figure 4.1 Comparative Data Process

The data, indicative of our performance, is widely shared at all levels of the facility, electronically (e.g., websites) and/or hard copy. Areas identified in need of improvement result in the Plan, Do, Study, Act (PDSA) performance improvement model (Figure 6.4) being employed.

A Staffing Review was conducted by a multidisciplinary team. It focused on staffing levels for each Service. An extensive search for benchmark data was conducted, resulting in numerous benchmark staffing data. For staffing areas without benchmarks, comparisons were made with dashboard (like) VA facilities.

4.1a(4) Keeping Performance Measures Current – From the Network, data on key measures are updated on a monthly/quarterly basis, comparing performance with previous periods to assess current levels of

achievement. Data is used to compare relative success of our accomplishments against those remaining facilities in the Network, as well as overall Network data in comparison with other Networks in VHA. Our databases are also updated monthly to ensure up-to-date, moving comparisons over time. In addition to goals set by the VHA, our performance requirements are derived from standards established by numerous national committees for Quality Assurance, Joint Commission on Hospital Accreditation and Health Care Finance Administration.

Key Measures are evaluated on a regular basis and changed or modified as new priorities are identified. The establishment of three CBOC's in the last four years is evidence that measures have been improved to be more closely linked to business drivers or goals.

4.1b(1) Analyses Performed to Support Performance and Planning – There are methods used to analyze data that include trending analysis, projections, root cause analysis, and cost ratios (Figure 4.2). Each service, analyzes and trends data to include into the facility performance improvement process and improve patient care. The results are then reviewed and acted upon by our Senior Leaders at the Executive Leadership Council, local medical centers and key Network committees/councils.

Measures in the Director's Performance Plan are monitored very closely throughout the year. The Associate Director, Chief of Staff and Associate Chief of Staff for Clinical Operations monitor the administrative and clinical measures under their direction and report these results to the Strategic Planning Committee and the Governing Board. When deficiencies are noted, an action plan is developed to rectify the performance of these measures.

Tools	Why Used	Support
Trending	• Identify opportunities for improvement	• Performance measures • Strategic planning
Projections	• Anticipate needs • Resource allocation • Improve patient care	• Quality outcomes • Performance measures • Strategic planning
Root Cause Analysis	• Improve patient care	• Quality outcomes
Cost Ratios	• Determines efficiencies	• Performance measures • Administrative overhead

Figure 4.2 Methods for Data Analysis

4.1b(2) Communicating Results of Analyses – Monthly, data for the performance measures in the Network performance agreements are provided in a format that compares performance to a pervious time period, comparisons to the Network average, and to other Network facilities. This assists performance review and planning at all levels of the organization.

Effective lines of communication exist among the Resource Management Committee, the Administrative Leadership Council and the Medical Executive Committee for informing the respective administrative and clinical services of organizational level analysis needed to make informed decisions. Directors of individual services provide information in monthly meetings to their respective staff and supervisors. Work is progressing on a local web page that will afford all employees the ability to download pertinent data. Additional communication instruments include Director messages, the Daily Bulletin, and newsletters.

Example regarding our Waits and Delays Initiative: Six areas were identified as having waiting times for appointments that were not acceptable: Primary Care, Eye Care, Urology, Orthopedics, Cardiology, and Urology. The reengineering of these clinics resulted in decreased waiting times and delays for patients being treated in these areas (Figure 7.4.11).

4.1b(3) Aligning Analysis – In alignment with key business drivers, analyses of key organizational performance results have resulted in the development of action plans that are used to meet strategic objectives. A gap analysis is conducted for CPG/PI performance and action plans and best practices are shared for improving CPG/PI scores. Analysis of lab costs (Figure 7.2-6), radiology costs (Figure 7.2-5), and pharmacy costs (Figures 7.2-3 and 7.2-4), surgical costs, and coding accuracy are completed with action plans for improvement in costs submitted/reviewed by Senior Leaders and are accomplished. Figure 4.3 provides examples of analyses we use in our daily operations.

4.2 Information Management - 4.2a(1) Availability of Data/Information – Our facility, the Network, and VHA have an extensive, automated, data collection and dissemination system that assimilates and makes available a broad range of data and information to all

levels of the organization. Beginning at the site of patient care, data are entered by the health care team into a Computerized Patient Record System (CPRS) (Figure 4.4). This comprehensive system provides access to a range of data and information, including clinical, cost, and performance data that includes internal VHA comparative data. This information is used for issues such as tracking clinic access and third party reimbursement (Figure 4.5)

Data and information are made available via the Network Data Analysis and Information Office web page (http://152.128.95.15/). Postings to the web page are made on a routine basis, based on one-time requests for data and recurring reports. Access to information is available from user-friendly desktops in any location. Timely communication is accomplished via e-mail systems for both text and graphics. The implementation of the Electronic Medical Record (EMR) will result in one patient record immediately accessible to authorized users, 24 hours a day, 7 days per week, 365 days a year. Patients are able to refill their prescriptions via telephone and patient access to this service via the Internet is planned. Veterans currently have access to a web page that provides information on services (www.starsandstripes@med.va.gov).

Key Business Drivers	Type of Analysis
Placing Quality First	• Trends in Waits and Delays for Appointments • Reports of Root Cause Analysis • Performance of Preventive Care and Chronic Disease Indices • Outcome Monitors
Exceed Patient Expectations	• National VA Patient Satisfaction Comparisons
Maximizing Resources	• Education and Training Trends • Pharmacy Cost Trend • MCCF Collections (Figure 7.2-2) • Market Penetration Changes • Change in the number of patients treated • Cost per patient trends • Resource Allocation Analysis

Figure 4.3 Data Analysis Used to Measure Performance

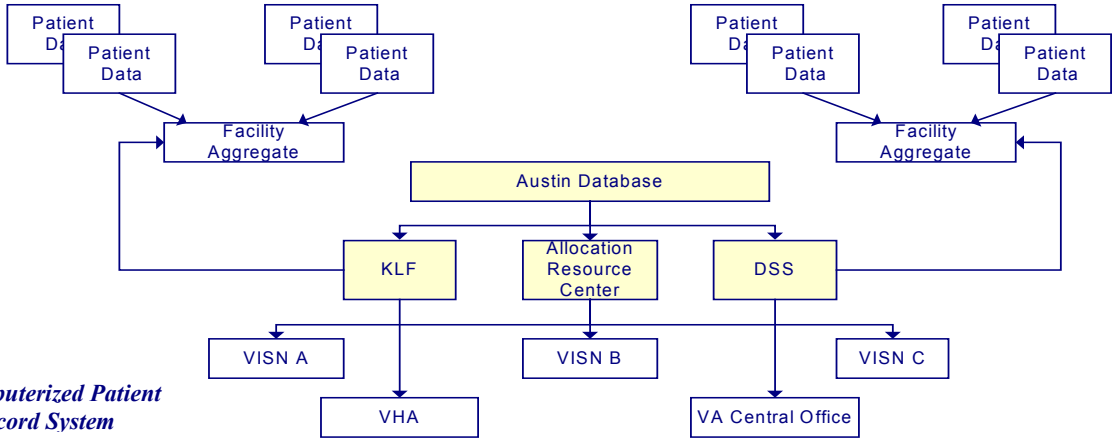


Figure 4.4 Computerized Patient Record System

	Network	Facility
Patients/Customers	• Newsletters mailed to all VISN patients • Management Assistance Councils (MAC) provide face-to-face program and performance updates to veteran service organizations, benefit advisors and educational partners	• Communicate satisfaction scores and related improvement efforts. • Town meetings used to make information available and to address concerns. • All patients can request copies of any information that VHA has about them
Suppliers/Partners	• Management Assistance Councils provide face-to-face program and performance updates to veteran service organizations, benefit advisors and educational partners	• Contract health providers in communities are linked to CPRS as indicated • Local educational partners included in Mini-Management Assistance Council meetings

Figure 4.5 Information Available to Customers/Suppliers

Customer satisfaction survey data is posted to make veterans aware of this measure. Vendors and suppliers are granted access to needed data inside the VA firewall, via such secure Internet products as Secure Net.

Improvements have been noted in the electronic dissemination of information in the last few years, as evidenced by the 2,600 web sites in VHA alone. Figure 7.4-14.

4.2a(2) Data Integrity, Reliability, Accuracy, Timeliness, Security and Confidentiality – Security of the information system is maintained through hardened user access and the use of verification passwords throughout the organization. Figure 4.6 depicts the security development process. Access to patient information is limited to those with a "need-to-know" and provides them with password-protected access to patient files. Audits are conducted to ensure only authorized staff has access to patient files. Information security is included in new employee orientation and in ongoing educational offerings.

An Information Security Officer and a Compliance Officer have been designated to maintain control of electronic system access and system integrity, reliability and optimization of equipment.

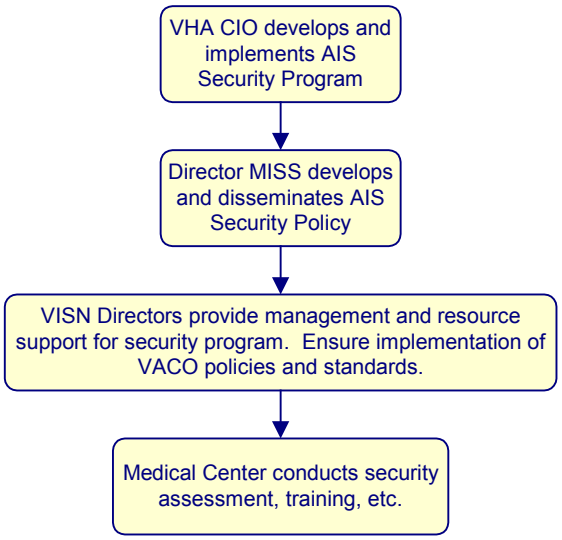


Figure 4.6 Computer Security Process

Information Security Training is provided at New Employee Orientation and is conducted as part of our Medical Center's Mandatory Review Process. All employees are provided with a password and log-on procedures and each employee must sign a "Rules of Behavior Agreement". All systems mandate strong passwords (mix of alpha, numeric and special characters), which must be changed every 90 days.

Patient confidentiality is maintained through the use of user access privileges which are assigned according to position and job responsibilities. Log reports are monitored for access to sensitive patient data.

4.2a(3) Data and Information Availability Mechanisms - Through the consistent deployment of VISTA and Microsoft products, users enjoy a uniformity of software. There are clear communication lines within IM to ensure that user needs are identified and resources provided. Through the support of VHA, we continuously improve the availability, quality and reliability of information as shown in Figure 4.7.

Timely VISTA patch installations improve the system as needed. Microsoft Outlook allows for easy communication between medical centers, Network offices, and VHA.

4.2b(1) Hardware and Software Reliability - The Information Management Work Group (IMWG), a subgroup of the Information Management Committee (IMC), was established to review requests for software and hardware procurements, and make recommendations to the IMC. They maintain a registry of all equipment, recommend new computer technologies, and ensure the integrity of computer pathways.

An annual needs assessment is conducted and is reflected in the Strategic Plan. Needs are continuously reviewed and updated to reflect the changing priorities of the organization. A prioritization of these computer needs is developed, thus facilitating their purchase.

4.2b(2) Currency of Software and Hardware Systems – A Network Information Management Strategic Plan aims to ensure the latest, affordable software and hardware system is available to the Network and its medical centers.

As a technological leader in the Network, this facility introduced the utilization of Thin Clients (narrow monitors) at our facility and satellite clinics. Our current count of 320 is 31 % of our total devices.

Our stand-alone imaging system in radiology is the first in our region. No other community hospitals have such a system. We are the second facility in our Network to deploy VISTA Imaging, which allows users at workstations to capture and view clinically significant diagnostic images in conjunction with VISTA medical record.

Group	Purpose	Improvements Made
PMW	Improve the quality and reliability of VHA's performance measures	• 2000 – Provide field with software for web based graphing and relational assessment capabilities so that performance graphs are automatically displayed and user can state what comparisons they want to see. • 2001 – Collecting larger sample performance information from Contract and Community Outpatient Clinics, so more reliable information is available about quality. • 2001 – Provided each facility with hand held survey instrument hardware device that is linked to national server so field can tailor the customer satisfaction questions they ask to address local needs and still link to national questions and national data.
DSS	Cost Data	• 2000 – National Data Extraction System that allows comparative information of cost data. In the past, if national comparative data was needed across Networks, had to access each Network's data separately.
CPRS	Electronic Patient Record	• 2000 – Link Textual documents to VISTA Imaging files; Ability to view data from other facilities where the patient was seen; Ability for clinicians to use reminder dialogues to collect clinical data and build a progress note simultaneously. • 2001 – Ability to share best practice clinical reminders and dialogs for clinical care; Enhance Pharmacy Order Entry for Clinicians.
Hardware and Software	Date Standardzation and Integrity	• 1998-2000 – Upgrading fiber optic backbone in all facilities so digital images, such as digital x-ray, can be stored and transfer of records is done more easily. • 1999 –2001 – Master Patient Index, which will allow all records of a patient that has been seen anywhere in the system to be accessible immediately. • 2000-2001 – Installing Microsoft 2000 across system; Remote data views from CPRS GUI; Text Integration Utilities. • 200-2001 – Working to design a single architecture and communication software that will allow communication access to all data across the Department; Clinical Reminder Exchange Toll; TIU Interdisciplinary Notes.

Figure 4.7 Continuous Improvements in Data Availability and Hardware

The medical center is heading towards a thin client environment that will minimize downtime for individual users in case of hardware failure. A newly developed web page is available to all employees and is used as a vehicle for dissemination of information. A Help Desk is staffed locally by personnel who provide centralized assistance for any software or hardware problems.

5.1 Work Systems for High Performance - WBVAMC is committed to being an "Employer of Choice" organization. The organization was recently restructured according to a service concept. Various career development and continuing education offerings help to provide employees with the knowledge and skill base that enables them to contribute to the strategic goals of the organization and personal goals for high performance. Performance measures are linked to continuing education requirements and provide the motivation and direction for continued growth and development.

5.1a(1) Organizational Culture and Communication – WBVAMC Senior Leaders' responsibilities, authority, and related communication flow are clearly delineated (Figures. 1.1, 1.2). Memorandums provide guidelines for organizing and managing the numerous processes across the Medical Center. Our organization's position descriptions are now tailored for multi-skill positions in order to have more flexibility in assigning job duties and to provide employees with new challenges and a broader exposure to learning opportunities.

An example of positive employee-oriented change was the Employee Suggestion Program. Employees have an opportunity to suggest ideas/improvements in the Medical Center. One hundred percent of all employees received thank you notes for their contributions. Suggestions have resulted in improvements that have positively affected quality of care and the work environment.

The Medical Center shares knowledge through numerous telecommunication links, and all employees have access to computers. WBVAMC has a Web Page with access to up-to-date data, access to best practices, and all types of information, including performance measures. Computer devices to facilitate communication have increased (Figures. 7.4-14).

5.1a(2) Motivation – Each employee meets with his/her supervisor semi-annually for feedback on performance and to establish short and long term goals, which include developmental activities. The organization has implemented the High Performance Development Model (HPDM) to motivate employees through mentoring and other activities. The focus of the HPDM is to develop a highly skilled, customer-focused workforce for the 21st

Century, and to develop a continuous supply of skilled leaders committed to the mission of VA. An action plan has been developed to ensure the implementation of the HPDM.

The Medical Center has embarked on a commitment to provide education on Covey's 7 Habits of Highly Effective People to assist staff to fully utilize their potential and promote organizational culture change. Increasing number of employees has completed this education (Figure 7.3-5).

5.1a(3) Performance Management and Recognition - The Medical Center uses a conceptual model for creating a learning organization to promote employee development, the High Performance Development Model (HPDM), as discussed in 5.1a(2). Core competencies have been incorporated into the competency assessment of all employees and the Reward & Recognition Program.

All employees receive semi-annual performance appraisals, which are conducted by the immediate supervisor in face-to-face meetings to provide feedback on performance. A competency checklist has been developed for all employees with variations dependent on job classifications. Supervisors meet with associates at the work unit level to review the checklist developed for each associate for feedback, buy-in, and accuracy of individual's competency.

Ongoing measurement of incentive awards indicates an increase in employee recognition (Figure 7.3-6). For the first time in four years, in FY 2002, the Medical Center hosted an awards program ceremony. Approximately 200 employees (20%) received recognition for the contributions they made toward achieving the strategies/objectives of the organization.

5.1a(4) Succession Planning - WBVAMC is in the process of developing a well-defined approach to succession planning. Mentoring programs are in process of development. The formation of Individual Development Plans has been introduced. Other leadership development opportunities include National Nursing Education Initiative (NNEI), Leadership VA, and Health Care Leadership Institute.

5.1a(5) Recruitment - The skills and abilities of our staff are directly linked to our Mission, Vision, and Values. Annually those needs are reviewed by leaders and revised through strategic planning, budget planning and human resources review processes (Section 2.2(a)). The participation of our labor partners extends through the human resources planning processes to the hiring process. Managers and Supervisors identify the characteristics and skills needed by each position and complete an accurate position description. Recruitment is conducted by utilizing the Office of Personnel Management and the VA's Delegated Examining Unit (Figure 5.1). The Medical Center attempts to attract a diverse pool of candidates. Programs to enhance recruitment efforts include Education Debt Reduction Program, National Nursing Education Initiative, and Employee Incentive Scholarship Program. For healthcare vacancies, the Medical Center advertises in Healthcare Journals, Newspapers, Historical Black Colleges, and local television. The WBVAMC closely compares to the local community in a diverse workforce and has exceeded target goals in the employment of persons with disabilities (Figure 7.3-14).

5.2 Education and Training – 5.2a(1) Action Plan Achievement - Knowledge, skills, and abilities required for current and future positions related to the VA's mission are reviewed through semi-annual or annual competency assessments based on the HPDM. As a result, Staff Development Educators plan and implement training, then evaluate outcomes according to their impact on the organization's short- and long-term goals.

All employees have the opportunity to suggest programs during the evaluation process of all educational activities. This feedback is factored in the development of short-term objectives, such as: educational needs and supervisory needs are assessed annually via feedback directly from employees. These needs are prioritized using established criteria. For example the CPRS/GUI initiative (Fig. 2.6) has resulted in ongoing education for continual improvement.

In developing educational opportunities, the education and occupational level (figures 0.3 and 0.4) are factored into the course content, delivery method of the material and tools utilized during the process (figure 5.3).

Employee Type	Key Performance Requirements	How to Recruit/Hire	How to Retain
Leaders and Managers	Government and specialized VA qualification requirements	• Internet & Intranet advertising	• Meaningful work • PublicService Ethic
Physicians	Licensing and Certification	• Recruiting fairs • College recruiting • Academic advertising • Residencies	• Competitive pay practices • Technical advanced equipment • Relocation bonuses
Registered Nurses	Licensing and Certification	• Diverse advertising	• Training & education • Tuition reimbursement
Pharmacists	Licensing and Certification	• Academic advertising	• Tuition reimbursement • Competitive pay practices
Professional Staff	Technology Accreditation Certifications and Registrations	• OPM • VA Delegated Examining Unit	• Flexible work schedules • Team environment
Support Services	Program guidelines	• Merit Promotion • Upward Mobility • Cooperative education • Special emphasis	• Recognition • Technology • Equipment

Figure 5.1 Recruitment Methods

There are several performance measures related to education. In Fiscal Years 2000 through 2002, the WBVAMC exceeded the required percentages for employee training at 51.3%, 62.1%, and 87.8% (Figures 7.3-1 and 7.3-2). WBVAMC has also invested more dollars in employee continuing education, which encourages the growth and development of employees (Figures 5.2 and 7.3-3).

Function	How Education & Training Has Supported Cultural Change
Licensure	Quick access via VETPRO
Development	VISN supervisory education series, Covey Training
Leadership	Succession planning and career development plans
Critical care	Clinical practice guideline
Cancer progression	Assessment & management of pain

Figure 5.2 Linkage of Education to Culture Development

5.2a.(2) Employee Input - An annual Educational Needs Assessment is sent to all employees by the Office of Staff Development. Outcome data is reviewed, prioritized, and submitted to upper level management with a proposed education plan addressing these needs. Each educational activity participant is also afforded the opportunity to provide suggestions for future classes. Adult learners' education modalities are considered in the program design (Fig. 5.4), and a delivery strategy tool is used in the selection process. Recommendations from class evaluation forms are incorporated into future classes.

5.2a(3) Addressing Educational Needs – Many training events have been developed and provided to employees in a number of key areas, all of which are aligned with organizational key strategies, goals and objectives (Figure 5.3).

5.2a(4) Education Delivery & Evaluation - The educational process begins with assessment of a need for knowledge with the impact on strategic planning process and advances through stages of planning, implementation, and evaluation. Recognizing the diversity of our workforce, both formal and informal methods of delivering education to our employees are provided (Figure 5.4).

Pre- and post-tests are administered for selected educational activities as indicators of learning. A program evaluation is completed on each educational offering to present participants with an opportunity to assess achievement of personal and class objectives. Participants rate items on a Likert scale of 1-5 (Poor to Excellent).

5.2a(5) Reinforcement – The organization has evaluations for training events that determine participant behavioral change (Figure 5.5).

Positive reinforcement of learning and resultant behavioral change occurs through several processes that strengthen and reward improved performance. There are many effective mechanisms available to ensure that the use of knowledge and skills on the job are reinforced (Figure 5.6).

Key Areas	Examples of Training Topics	Common Delivery Modalities	Criteria for Modality Selecton
Technology Change	• Bar Code Medication Administration (BCMA) • Computerized Patient Medical Record (CPRS)	• National conferences (didactic) • Self-study via PC or internet-based modules	• Ideas to be demonstrated and shared • Self paced, just in time capability
Management Leadership Development	• Leadership Skills (e.g., Motivating employees, strategic planning, performance/quality improvement, HPDM)	• VHA Mentoring Program • Healthcare Leadership Institute	• Personal contact, human interaction needed • Immediate feedback, face-to-face interaction
New Staff Orientation	• Organizational Overview (e.g., One VA) • Employee and Patient Safety • Sexual Harassment • Computer Skills	• Small group meetings • Learning Maps • Self-directed study on PC • Training films	• Share ideas • Structured content • Self paced, ability to test out • Consistent content, cost effective
Safety	• Employee and Patient Safety • Hazardous Materials • Risk Management • Emergency Preparedness	• National conference (didactic) • Satellite conferences • Self-directed learning modules • Computer-based training • Mandatory review	• Ideas shared and demonstrated • Structured content, cost effective for national programming • Self paced with just in time access
Performance Measurement / Improvement	• Waits and Delays • Performance Plans • Clinical Guidelines • Special Program Capacity	• Internet sites • • Satellite conferences • Classroom	• Contact with large audiences • Consistent content • Face-to-face sharing, same location
Diversity	• Mediation • Alternative Dispute Resolution • Equal Employment Opportunity (EEO)	• National Conferences • National diversity tool kit with variety of education materials • Mandatory training • Satellite broadcasts	• Ideas shared nationally • Structured content, references to future use • Self-paced, cost effective • Consistent content

Figure 5.3 Training Events

Formal Training	Informal Training
• Classroom instruction • Clinical practice labs • Video-conferencing (V-Tel) • Satellite conferencing • Audio-conferencing • Conferences, workshops & retreats • Train-the-Trainer Programs • Self Study Modules • Learning Maps • Grand Rounds • Mentoring Programs • Closed-circuit TV • E-learning with private vendors • E-learning with VHA developed products	• Use of library resources (books, videos, pamphlets, etc.) • Use of videos • Staff forums/town meetings • Precepting, coaching and informal mentoring within work units • Audiographics • Computer-based Training • Web-based Training

Figure 5.4 Methods of Training

Programs	Outcomes
Waits & Delays Program	Decreased waiting times, increased access to care
MCCR Training	Increase in revenue collections

Figure 5.5 Training Outcomes

5.3 Staff Well-Being and Satisfaction - 5.3a. Work Environment - There has been improvement in the work environment for employees and the safety of patients has been noted, as evidenced by documented reduction in Lost Time Claims Rates and Office of Workman's Compensation Program costs.

Staff is involved in improving workplace health and safety (Figures 5.7, 7.3-12 and 7.3-13). Our safety committee review and analyze health and safety concerns and incidents and accidents to determine cause and identify improvement strategies. This committee has broad employee representation of over 2% of the employees including union partners and onsite safety professionals.

A competency evaluation system has been put into place to assure that employees can safely perform their assignments. A Risk Management Program monitors patient safety, and Safety Office measures employee safety. Both programs investigate incidents to determine cause and establish preventive action and work cooperatively to identify trends.

Staff Classification	How Knowledge & Skills Are Reinforced On the Job
Leaders	• Performance appraisal process • Performance contracts • Formal & informal discussions with Network Director • Formal performance improvement plans • Rewards
Managers	• Competency checklists
Front-line Staff	• Performance appraisals • Proficiencies • Awards • Individualized development plans • Competency checklists • Credentialing and privileging

Figure 5.6 Reinforcement of Knowledge/Skills

Work Function	Staff Involvement	Measure	Targets
Health Clinical Staff	• Infection Control Committees • PPD tests • Physical exams or screening tests • Hepatitis inoculation • Flu vaccination • Employee Assistance	# of needle stick injuries	Decrease sticks by 2%
Safety – All Employees	• Education programs ongoing and annually • Emergency drills • Safety Officer	• Lost times claims rate • Accident Rates	Reduce risk to achieve LTCR of < 2.68
Ergonomics – All Employees	• Job site evaluations • Ergonomic Program • Job design • Hazardous Surveillance rounds • OWCP Coordinator	OWCP Costs	Decrease OWCP Costs

Figure 5.7 Staff Well-Being Improvements

5.3b(1)Employee Satisfaction – For the past two years, the facility has administered the Gallup Q-12 Survey to all staff. Results of the survey are aggregated by the work unit, department, Medical Center, and the Network as a whole. Following each survey, all managers and supervisors are trained on how to interpret the results, and how to best respond to obvious findings. Managers and supervisors are required to meet with their employees to discuss the findings, and to develop action plans for addressing problem areas.

Senior Leaders meet regularly with our local union partners (Labor-Management Partnership Council) to discuss a wide variety of issues related to bargaining unit employees. On a quarterly basis, our Human Resources Services and EEO Manager collect and aggregate by facility, data related to a number of measures that are considered to be direct or indirect measures of employee satisfaction. These include turnover rates, grievances, EEO complaints, separation analyses, and, sick leave usage rates. Reports are made available to Senior Leaders.

Employees provide feedback on satisfaction issues during a variety of formal and informal forums. The Director conducts monthly town meetings for all employees to inform them of current issues and share their concerns. An employee suggestion box and employee development seminars add additional means of ascertaining employee satisfaction. Employees are provided feedback on their suggestions.

5.3b(2) Employee Services and Benefits - WBVAMC supports a diverse workforce through the delivery of a wide variety of services, benefits and policies. All full-time and regularly scheduled part-time employees receive a full range of basic employment benefits (Figure 5.8). Through these programs, the Facility is able to tailor the needs of a diverse workforce and different categories and types of staff.

5.3b(3)Satisfaction Assessment Methods - Employees have participated in the Gallup Q12 satisfaction survey. Opportunities for improvement are identified and results are trended to analyze effectiveness of actions implemented. Employees also participate in the "One VA" survey, which provides benchmarks to compare satisfaction with the Network and entire VA. Measures linked with staff well-being, satisfaction, and motivation include disciplinary action rate (Figure 7.3-6), adverse action rate (Figure 7.3.7), sick leave (Figure 7.3-8), Equal Employment Opportunity complaints (Figure 7.3-9) and unfair labor practices charges (Figure 7.3-10).

Support Services	Support Benefits
• On-site development & wellness classes • Upward mobility training • Leadership training • Paid or unpaid leave for education • Paid travel costs for approved off-site training • Network scholarship program • Career counseling • Mentoring • Credit Unions • Smoking cessation • Flexible work opportunities • Telecommunication • Job sharing • Light duty assignments	• Immediate, accruable & advanced vacation & sick leave • Holiday leave • Health benefits • Life insurance • Retirement plans • Government contribution • Loan options • On-the-job compensation • Education leave • Leave sharing or donor program • Family sick leave

Figure 5.8 Support Benefits

5.3b(4) Improvement Priorities - Performance improvement teams use techniques to prioritize improvement activities and submits recommendations to the Medical Center-wide Performance Improvement Committee. Performance improvement project teams are chartered based on identified priorities, such as alignment with the Medical Center mission, vision, strategic plan, key business drivers, goals, and performance measures. A Staffing Review Team was

assigned to assess staffing levels across the Medical Center. Staffing benchmark standards were used for comparative analysis as available. When unavailable, dashboard VA facilities that were similar to Wilkes-Barre were used for comparative data. Since FY 98 staffing levels have been reduced from 988.8 to 925 in FY 01 (Figure 7.2-11).

6.1.a(1) Design Process - WBVAMC designs new processes, programs or systems that are consistent with the following criteria: the Medical Center's Strategic Plan, stakeholder expectations, clinical considerations, sound business practices, and established performance improvement results and expectations. A new process or improvement of an existing process may be initiated from any level of the organization; however, it is the Strategic Planning Committee (Figure 2.1) that receives input from VA and non-VA sources to establish strategies and set priorities for new service and product design (Figure 6.1). The Governing Board, Medical Executive Committee, Administrative Leadership Council, and Performance Improvement Steering Committee oversee the actual design, operationalization, implementation and monitoring of approved processes throughout the organization. An example is illustrated by the expansion of current Community. These clinic creation/expansions has increased outpatient visits (Figure 7.2-9).

6.1a.(2) Patient/Market Requirements - The availability of demographic and specific data sources from VHA, VBA, Network, community, and the Medical Center (Figures 7.2-9 and 7.2-10) combined with input from our stakeholders, particularly our patients, provides necessary input into our decision-making process for service design and delivery (Figure 6.1). Patient satisfaction surveys, market analysis, prevention indexes, and information gathered from patient representatives and service officers are used to determine design needs for the Medical Center. For example, data and patient input demonstrated the need for a better process for the scheduling of appointments resulting in the "Waits and Delays" initiative to provide more timely access to care (Figure 7.4-11).

6.1a(3) New Equipment/Technology – Medical Center personnel obtain knowledge about new equipment/technology through a variety of sources: peers, executive sales personnel, trade shows/journals, as well as Network and VHA sources. Service line leaders evaluate the need, efficacy, and cost benefit for purchases of new equipment/technology and make recommendations. The Equipment Committee reviews equipment purchase requests, while the Information Management Committee reviews requests for hardware/software purchases.

6.1a (4) Addressing Efficiency/Effectiveness Factors - The design/redesign of our health care services are driven by these factors: root cause analyses, customer satisfaction surveys (Figures 7.1-1, 7.1-2, 7.1-3, 7.1-4, 7.1-7 and 7.1-11) utilization management, cycle time considerations, clinical practice guidelines (Figures 7.4-1, 7.4-2, 7.4-3, 7.4-4 and 7.4-5), and VACO or Network directives. Data collection and process mapping are utilized to achieve higher levels of efficiency, performance, and patient satisfaction. Pilot programs are also utilized to test designs. Transfer of learning is addressed by the Performance Improvement Steering Committee, which monitors, reports, and initiates improvements based on performance results. One such initiative involved patient fall prevention. Extended care units demonstrated a lower number of patient falls when compared with acute care units. Practices that were commonplace on extended care units were adapted for use on acute care units to achieve similar results (Figure 7.4-8).

6.1a (5) Production and Delivery Systems – WBVAMC improves and maintains quality through a comprehensive performance management system that defines measures to track progress in meeting established performance goals and regulatory requirements. Our processes are governed and designed in accordance with VHA and the Network established performance requirements as well as those set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Network and other regulatory and accreditation agencies such as the FDA, NRC, CAP, CARF, etc. Internal requirements and performance measures built into the performance management system, are driven by our key business drivers. Easy access to care is demonstrated by our waits and delays comparisons (Figure 7.4-11).

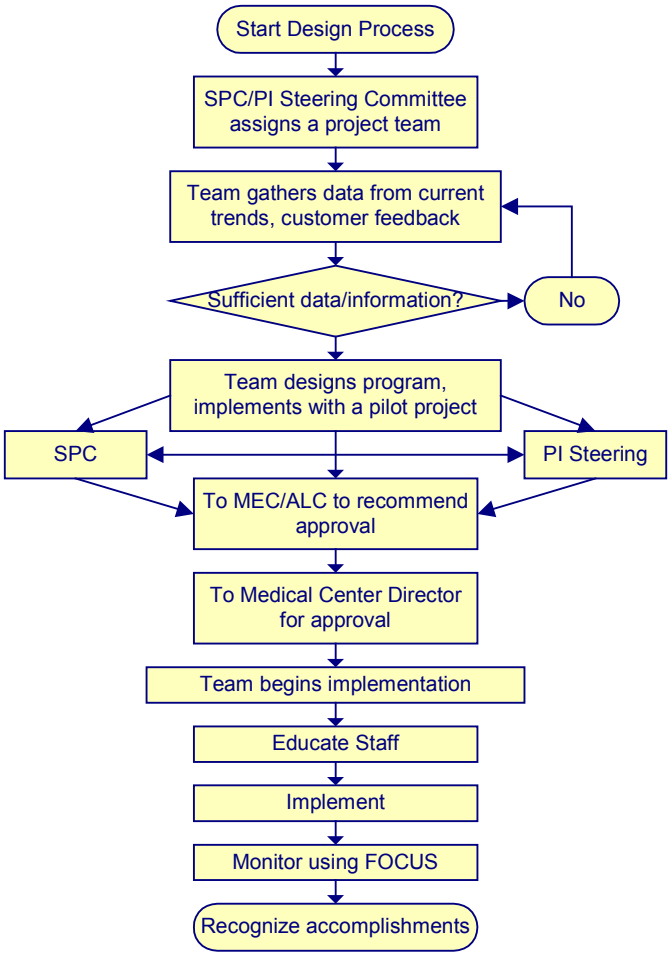


Figure 6.1 Design Process

6.1.a (6) Testing Delivery/Design Systems - The measurement systems used provide coordination and testing for the design and delivery processes. Through the use of pilots, new products/services are designed. Collaborative and specific indicators of both key processes and outcomes of care are designed, measured and assessed by our Service lines. Attributes of these measures include objectivity, measurability, and are based on current knowledge and experience. The structure of the measures is designed to produce valid performance measures of care and service provided. External sources, such as benchmarks and performance of similar processes in other medical centers, are also utilized. Outcomes of testing and design systems are reported to the Medical Executive Committee/Administrative Leadership Council through the Performance Improvement Steering Committee, with recommendations reported back to Service line directors for action.

6.1.b (1) Production/Delivery Process - The Health Care Processes (Figure 6.3) are developed for the strategic plan by leadership. Requirements and related measures include: access, timeliness, (Figure 7.4-11), satisfaction and health promotion and disease prevention.

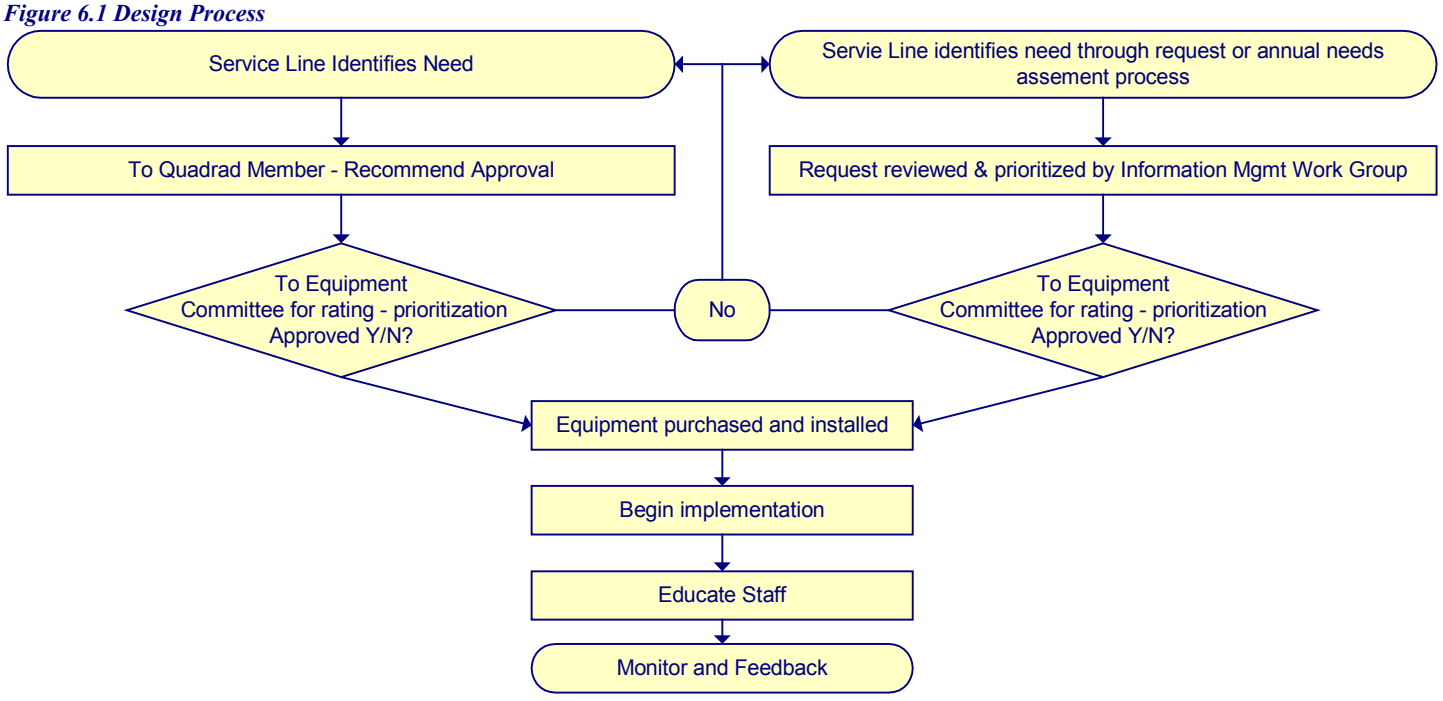


Figure 6.2 Equipment/Technology Purchasing Process

Business Drivers	Health Care Process	Requirements	Measures	Figures Referenced
• Easy access	• Primary Care	• Access	• Waiting Times for Clinic Appointments (30 days or less)	• 7.4-11
• Quality First	• Surgical Care	• Quality	• NSQIP (continued decrease % of morbidity & mortality rates)	• 7.4-6 and 7.4-7
• Quality First	• Long Term Care	• Safety	• Restraint Use (goal = 0% use) • MDS/QIR (goal under review by VHA)	• 7.4-9
• Quality First	• Behavioral Health Care	• Quality	• Screening for Major Depressive Disorder (goal – 92% screened)	• 7.4-3
• Exceed Patient Expectations	• Acute Care	• Emotional Support	• Diabetic education (HbA1C<9) (goal – 81%)	• 7.4-1
• Easy Access	• Clinic & Diagnostic Services	• Timeliness	• Turnaround times for imaging/diagnostic reports (goal = 48 hours)	• 7.4-13
• Exceed Patient Expectations	• Physical Medicine	• Patient Satisfaction	• (goal = exceeds average score of 3)	• 7.1-7

Figure 6.3 Health Care Processes

6.1.b (2) Day-To-Day Operations - Key measures of performance for processes are directly related to the service provided and the clientele served (Figure 6.3). Performance requirements are disseminated throughout the Service Lines. In turn, the Service lines assess, deploy plans, and monitor their daily operations to determine their level of achievements associated with each measure. A monthly status/accomplishment level is formally conducted through the Performance Improvement Steering Committee and reported to the Medical Executive Committee, the Administrative Leadership Council and the Director. These committees utilize statistical controls to assure that performance targets are met and are aligned with our Strategic Plan, key business processes (Figure 6.5), and controls (Figure 6.6). Our Compliance Officer monitors the facility's compliance with established requirements for such areas as billing and medical record documentation.

6.1.b (3) Controlling Processes/ Inspections/ Audits – WBVAMC utilizes numerous measures of access, quality of care, and efficiency (Figure 1.3). Patient advocacy allows for real-time responses to patient input. "In-process" measures occur for high areas of vulnerability including: contract compliance with vendors/suppliers, finance, medication use, and mock surveys. Automated systems are in place to audit finance, controlled substances, and portions of compliance and billing, which provides an element of efficiency and objectivity to our review processes.

6.1.b(4) Inspections and Audits - Process audits/inspections include internal and external reviews of established performance measures that incorporate comparisons to best practice and benchmarks, as well as compliance with regulatory/payor requirements. Process owners complete internal reviews of processes. Results are reported through the Performance Improvement Steering Committee to the Medical Executive Committee and Administrative Leadership Council for review/action. Many external audits, monitor compliance with policy or are completed by regulatory/payor agencies for adherence to established guidelines.

6.1.b (5) Improvement of Health Care Service Delivery Systems and Processes - The FOCUS-PDSA model (Figure 6.4).

6.2 Business Processes - 6.2.a (1) Business Processes – Figure 6.5

6.2.a(2) Business Processes Requirements – Overall direction and guidance is established by the Network through dissemination of our Strategic Plan and the Network's Nine-Point Plan. Service Line Chiefs are tasked with overall management of the key business processes.

6.2.a(3) Indicators for Control Processes –Key performance measures/indicators used for control and improvement (Figure 6.5). Continuous monitoring is accomplished using the model for performance (Figure 6.4) to improve processes.

6.2.a(4) Design Business Processes – Service Lines design the process and develop tactical action plans with

specific action steps and performance measures to implement the goals. The Strategic Planning Committee analyzes the plans and incorporates appropriate input from other internal customers, stakeholders and managers, as well as considers the process design in light of other established goals to determine priorities. Design processes have lead to a variety of community relationships to support our mission and Strategic Plan.

6.2a(5) Minimizing Auditing Costs – In-process measures, (Figure 6.6), provide continuous monitoring associated with inspections, tests, and performance audits. Performance is tracked at least quarterly to avoid costly rework. Assessment procedures are designed prospectively and continuous monitoring reduces the need to do audits retrospectively. Specific in-process measures include monthly coding audits, compliance audits, MCCF reports (Figure 7.2-2), and Prevention Index. Outside consultants are utilized, as needed, to provide an added level of expertise.

6.2.a (6) Improving Business Processes – A critical part of the process design includes identification and incorporation of benchmarks and best practices from industry, private health care, other Networks and medical centers within the Network. Once identified, these best practices are incorporated into the action plans and tracked by major hospital committees.

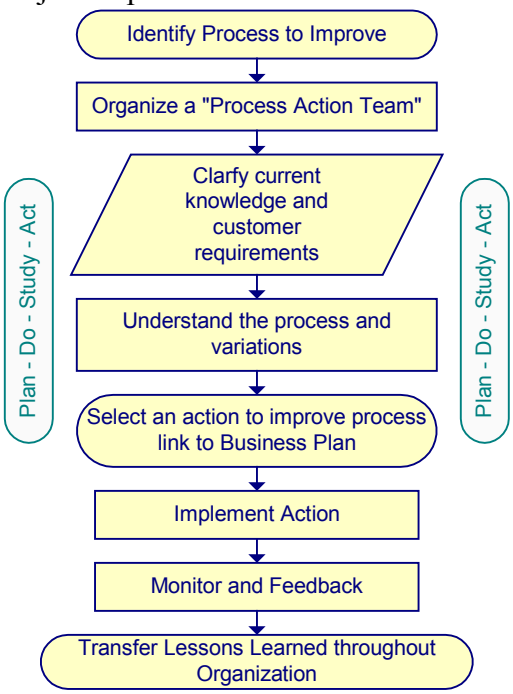


Figure 6.4 Model for Performance Improvement

6.2b(1) – Support Processes - Figure 6.7

6.2b(2)(4) Requirements and Designs for Support Processes – Key processes, process ownership and operational requirements are listed in Figure 6.7. Committees, comprised of key internal and external customers, design processes and develop tactical action plans to implement the goals established in the Strategic Plan and the Nine- Point Plan. As a support process is identified for design, the same design process is used as displayed in Figure 6.1

6.2.b(3)(6) Minimizing Costs and Improving Support Services – Key performance measures/indicators are used for the control and improvement of these identified processes (Figure 6.8). These data are analyzed, and results are used to determine priorities for improvement. Facility specific inspections and audits are rolled-up to insure overall compliance. Monitoring is continuous and part of the process using the performance measures listed, minimizing auditing costs and rework. Results and improvements are tracked at the Performance Improvement Steering Committee, Strategic Planning Committee, Medical Executive Committee, and Administrative Leadership Council. Where appropriate, Network level contracts are used to reduce costs, i.e., Compliance, JCAHO, continuous survey readiness, Waits and Delays, Gallup, etc. Local contracts (which include input from partners/suppliers) are used to minimize costs in medical supplies, pharmaceuticals, sustenance, and office supplies.

6.2.b(5) Indicators for Support Processes – Controls for the key support processes (Figure 6.8) are implemented with the direction, and guidance of the Governing Board and the Strategic Planning Committee through dissemination of the Strategic Plan.

6.2.b(7) Improving Support Processes – A critical part of the process design includes identification and incorporation of benchmarks and best practices from industry, private health care, other Networks, and medical centers within the Network. Once identified, these best practices are incorporated into action plans and tracked regularly by major hospital committees. (Figure 6.4).

6.3 Supplier and Partnering Processes – 6.3a(1) – Key products/services – the WBVAMC's key products and services, their performance requirements, and measures are listed in Figure 6.9.

6.3a(2) Performance Requirements – The facilities management section and/or contracting officer are responsible for ensuring that performance requirements are incorporated into the supplier/partner performance process. Detailed specifications are written which include measurable outcomes based on quality, price, and timeliness.

6.3a(3) Meeting Requirements – WBVAMC utilizes a COTR (Contracting Official's Technical Representative) to ensure that all performance requirements are met. The technical representative is familiar with the product/service required and provides feedback to the supplier through meetings, telephone contact, and correspondence. Payments are made when requirements are met. For example, the Berwick CBOC is a contract clinic with reimbursement based on the number of veterans enrolled as called for in the contract (Access to Care)

Business Driver	Business Process	Process Owner	Improvements	Process Requirements
Quality First	Information Management	CIO	• Improves availability of patient records	• Records available at time of appointment • Records available to off-site providers
Maximizing Resources	Supply Chain Management	Contracting Officer	• Economy of scale	• Cost savings
Maximizing Resources	Alternative Revenue Generation	Business Office/ MCCF	• Increases budget	• Collection goal • Accounts Receivable
Maximizing Resources	Distribution Resources	Facilities	• Supply cost management	• Supply costs
Quality First	Performance Management	Senior Leaders	• Quality and Efficiency	• Access to care

Figure 6.5 Key Business Processes

6.3a(4) Inspections/Tests/Audits – Continuous monitoring using "in-process" measures are used to control auditing costs. Contract compliance is utilized with vendors/suppliers for adherence to performance requirements (quality, timeliness). Overall inspection costs are minimized by providing for monetary penalties if performance targets are not met. This insures on time delivery of a quality product/service.

Key Processes	Measures/Indicators	In-Process Measures to Minimize Cost
Information Management	• Score on Performance Measures	• % Facilities utilizing the electronic medical record • % Implementation of clinical reminders • % Pharmacy orders entered into CPRS
Supply Chain Management	• Satisfaction with Immunoassay Contract • Management of Lab Costs (Figure 7.2-6) • Management of Radiology Costs (Figure 7.2-5)	• Cost avoidance with reference lab • Clinician satisfaction with contract • Cost per reportable visit
Revenue Generation	• % of MCCF goal attained	• Improve coding accuracy (inpatient/outpatient) • MCCF Collections
Distribution of Resources	• VOR • Nine-Point Plan • Cumulative Statistics	• Budget variance (expected/actual) • Implementation of action plan
Performance Management	• Balanced Scorecard • Facility Performance Plan	• # Inappropriate admissions/continued stays

Figure 6.6 Controls for Key Business Processes

6.3a(5) Supplier Assistance/Incentives – WBVAMC provides technical assistance to improve suppliers/partners overall performance and contributions towards the Medical Center's performance. Technical assistance is provided in the form of computer training/support for contract medical providers, developing vendor interfaces with VISTA computer system (PYXIS med stations, blood glucose monitors), and equipment (on line access to hospital database). Blanket purchase agreements and mandatory use contracts also provide financial incentives for suppliers and reduces costs in areas such as pharmaceuticals, medical equipment, and technology.

6.3a(6) Improving Partner/Supplier Process – As needs change, new strategies are developed to enhance the supplier process. For example, consolidated contracting activities at the Network level provides maximum cost savings which allows the organization to maximize service to veterans. The Pharmacy Benefits Management group consistently uses Blanket purchase agreements and mandatory use contracts to that end.

Business Processes	Process Owner	Operational Requirements
HRM	• HR Committee • Staffing Review Team	• HR Quarterly Measures • Staffing Methodology • Staffing Review Report
Environment of Care	• Safety Managers • OWCP Leader • Safety Committee • Facilities Management	**Timely**: • Distribution and issuance of NRM and minor construction funding • Analysis of change orders • Activation funding • High Tech/High Cost Fund
Staff Education	• Education Staff • Education Committee	• Staff Training Plan/Programs • Summit Meetings • Partnerships with EES and Outside Contractors • Staff Competencies
Business Plans	• CFO • Planner • Strategic Planning Committee	• VOR • Internal controls • Data quality • Performance Measures
Efficiency Analysis	• Strategic Planning Committee • MEC • ALC • Staffing Review Team	• Implementation of meaningful benchmarks • Development of information systems to track performance • Continuing enhancement of measures

Figure 6.7 Key Support Processes

Support Process	Nine-Point Plan Element Supported	Key Performance Measures/Indicators
HRM	• Reduce Administrative Overhead • Hiring Practices • Clinical Efficiencies	• 75% of managers and supervisors will complete TEMPO • Gallup Q-12 Overall Score
Environment of Care	• Expansion of Services • Paradigm Shifts • Enrollment • Waits and Delays	• # RCA's • # On-the-Job-Injuries • Lost times claims rate (Figure 7.3-13)
Education	• Technical and Perceived Quality • Clinical Efficiencies • Reduce Waits and Delays • Paradigm Shifts	• % Employees who receive 40 hours of continuing education/mandatory training (Figure 7.3-1 and 7.3-11)
Business Plans	• All elements in Nine-Pont Plan	• % Facilities who adhered to the Nine-Point Plan
Efficiency Analysis	• Paradigm Shifts (e.g. Administrative Overhead) • Clinical Efficiencies • Hiring Priorities • Reduce Waits and Delays	• % Accuracy for inpatient and outpatient record coding • % Improvement in clinic waiting times (Figure 7.4-11) • Cumulative Obligations per Unique Patient (Figure 7.2-1)

Figure 6.8 Controls for Key Support Processes

Business Drivers	Support Process	Performance Requirements	Measures
Quality First	Medical and Allied Health Affiliations	Quality of Care	Clinical interventions
Easy Access	Medical and Prosthetic	Quality/Timeliness/Access	Turnaround time
Easy Access	Pharmaceutical, Food, Nutrition	Response Times	Patient Satisfaction
Maximize Resources	Computer and Office	Quality, Responsiveness	% of Backorders
Healthy Communities	Contractors (Construction and others)	Timeliness, Safety	Contract compliance
Healthy Communities	Community Health Providers	Quality of Care, Responsiveness	Next available appointment

Figure 6.9 Key Products/Services

7.1 Customer-Focused Results – 7.1.a. Customer Results – WBVAMC has placed significant emphasis on inpatient and outpatient customer satisfaction in attempts to provide services "second to "none".

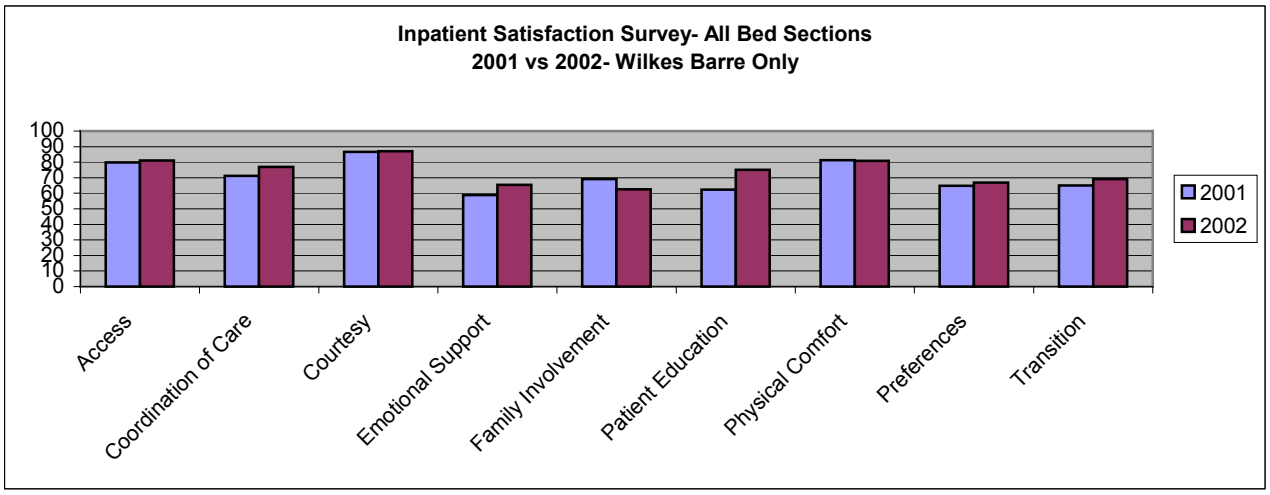


Figure 7.1-1 Inpatient Satisfaction Survey

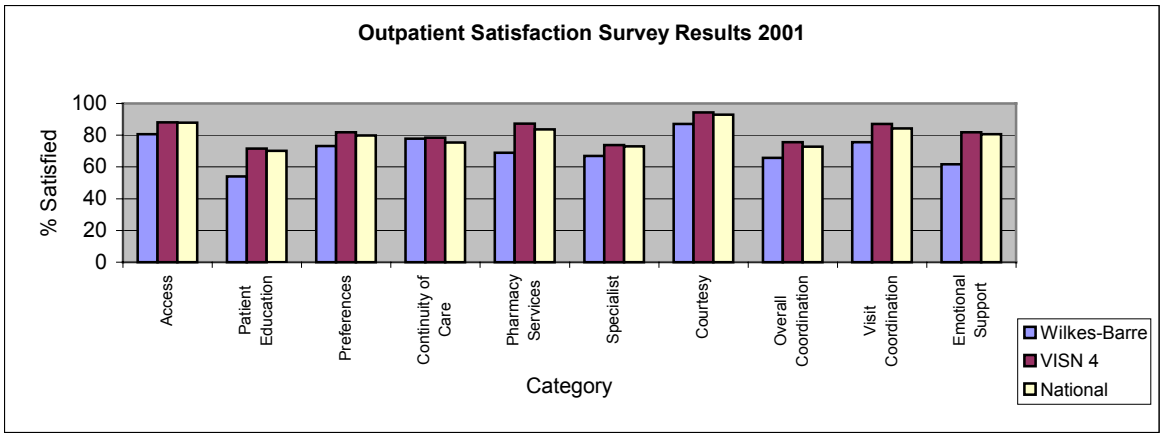


Figure 7.1-2 Outpatient Satisfaction Survey/

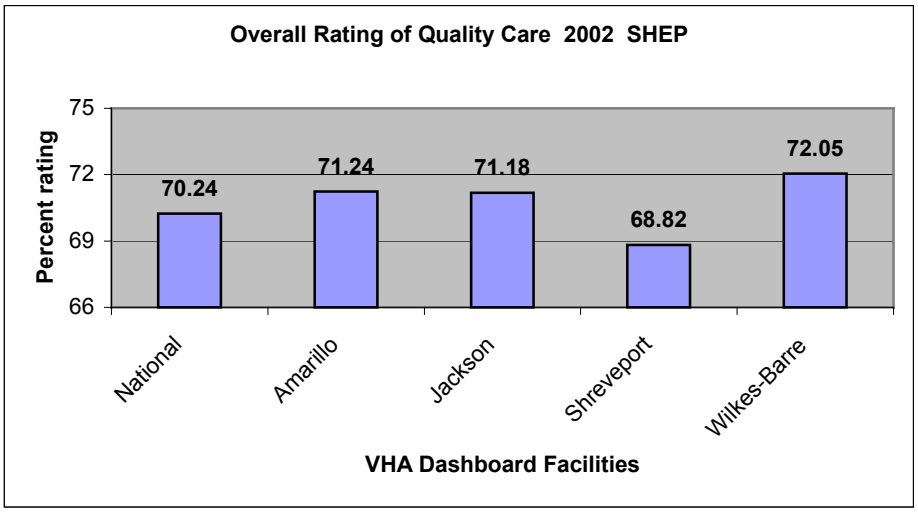


Figure 7.1-3 Overall Rating Quality Care - SHEP

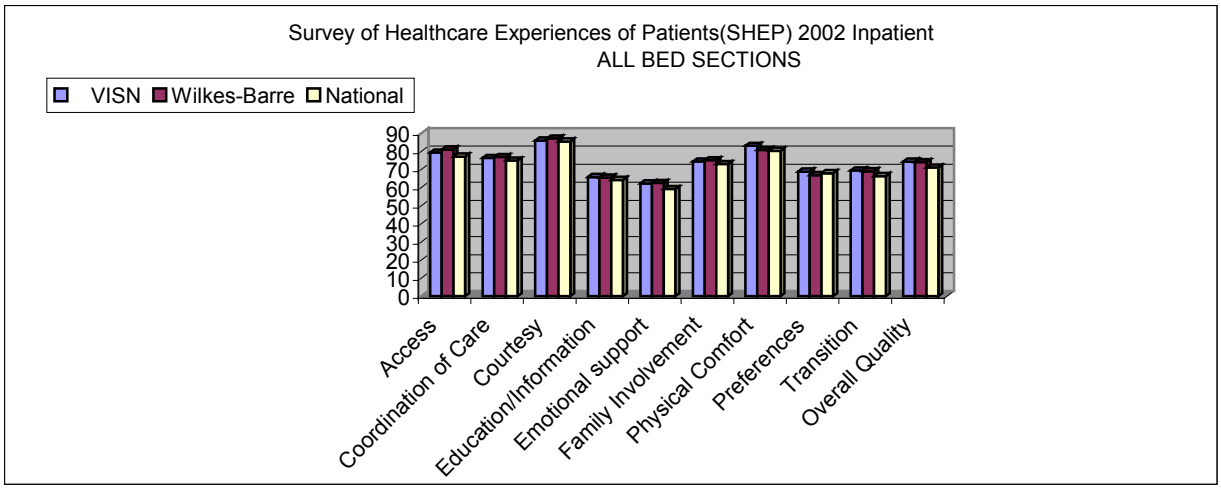


Figure 7.1-4 Inpatient SHEP Survey of Healthcare Experiences of Patients

In an effort to ascertain our performance regarding end of life, we participated in a VISN-wide bereavement survey of the individual most familiar with the resident or patient who died while in our nursing home and hospice programs. The tool used for the survey process was developed and validated by Brown University The survey was administered by a third party and consisted of satisfaction with care received by the professional staff, overall medical care, symptom control, death with dignity, emotional support for family and friends, and an overall rating. The score is based on a 10 point scale with 10 being the most satisfied.

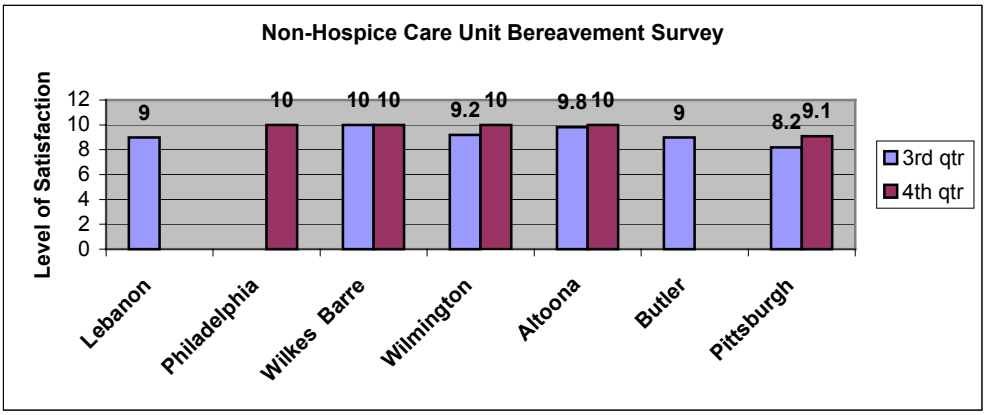


Figure 7.1-5 Non-Hospice Care Unit Bereavement Survey

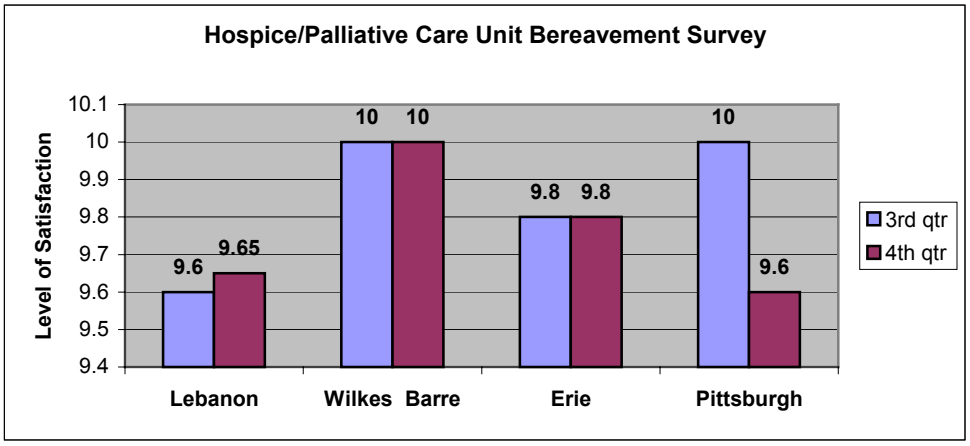


Figure 7.1-6 Hospice/Palliative Care Unit Bereavement Survey

As part of an initiative to align rehabilitation service delivery throughout the VHA system, the Medical Center obtained accreditation through the Commission on Accreditation for Rehabilitation Facilities (CARF). One requirement of this accreditation process is to identify level of customer satisfaction. In order to track and improve service or delivery, patients are surveyed upon discharge. Results indicate that Wilkes-Barre has exceeded the average score of three.

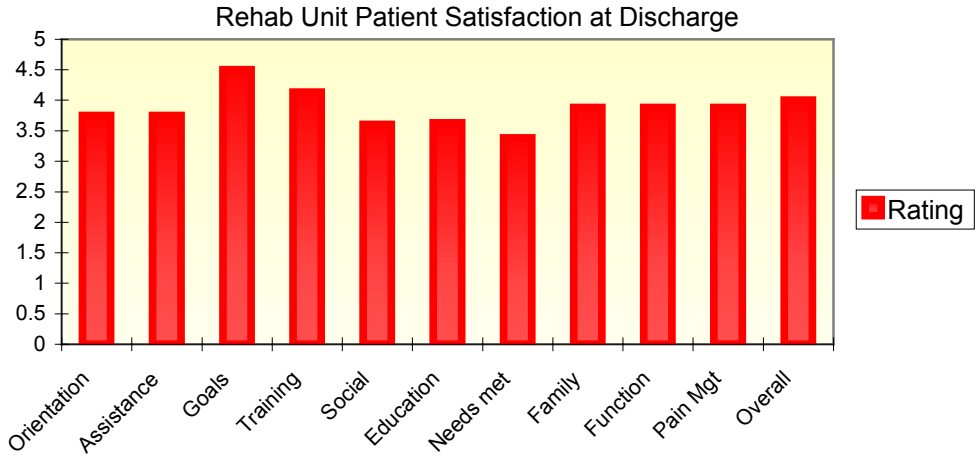


Figure 7.1-7 Physical Rehabilitation Satisfaction

The service area population demographics indicated a need for a Compensated Work Therapy Program (CWT) The CWT was recently initiated, as were methods to assess the customer satisfaction associated with this program.

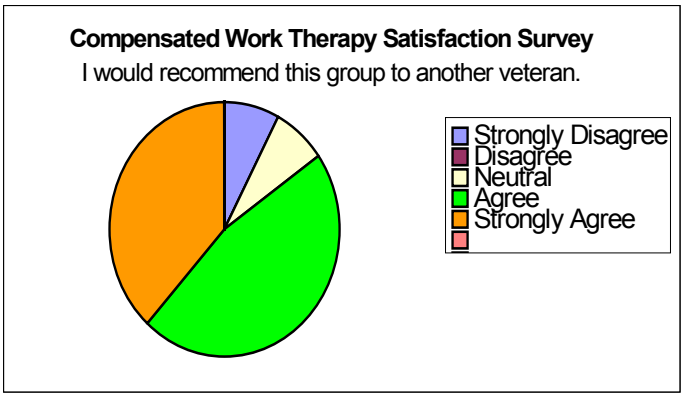


Figure 7.1-8 Compensated Work Therapy Satisfaction #1

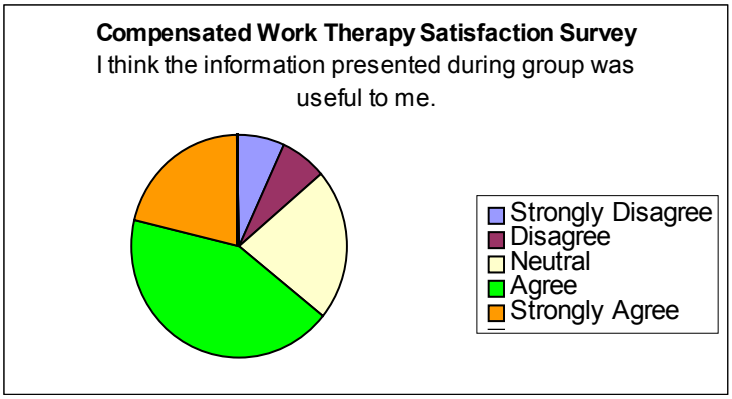


Figure 7.1-9 Compensated Work Therapy Satisfaction #2

7.1.b. - Product and Service Results - initiatives that resulted in improvement included access to care, continuity of care, and improvement of pharmacy services. Specific results associated with these areas of focus have been compared to the dashboard facilities, which include other VA Medical Centers that are most similar to this Medical Center in terms of size, services, and complexity.

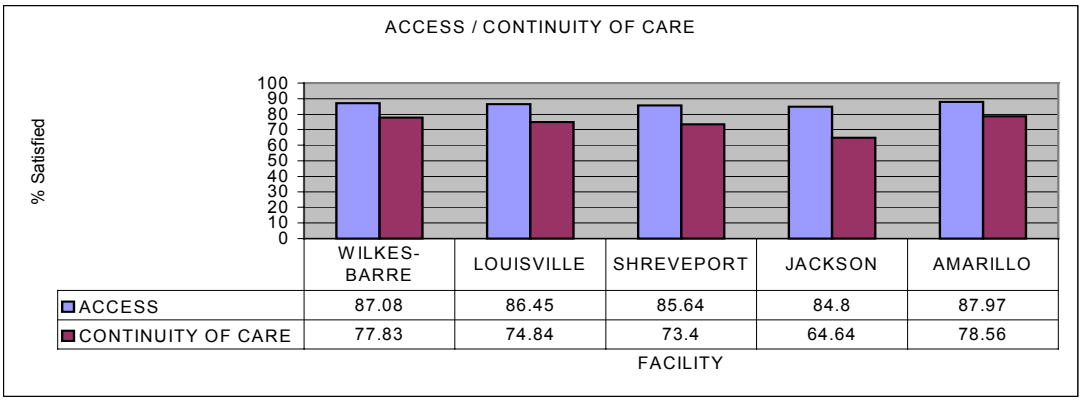


Figure 7.1-10 Access/Continuity of Care Satisfaction

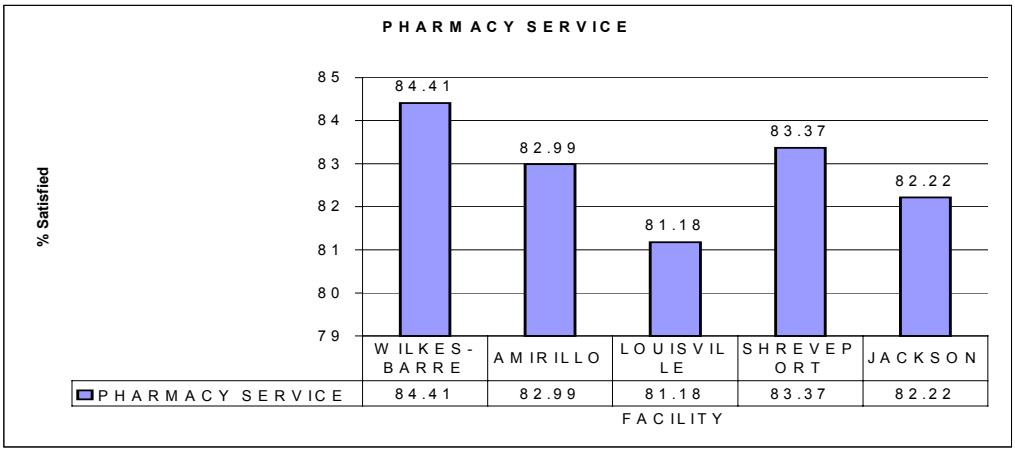


Figure 7.1-11 Pharmacy Service Satisfaction

The completion of compensation and pension examinations, which are physical examinations to determine the amount and level of veterans' benefits. An area where this Medical Center has consistently achieved processing time that is better than the target level and percentage of sufficient exams. This results in positive referrals from the Veterans' Benefit Administration (VBA) and provides positive experience to new users to the VA hospital system..

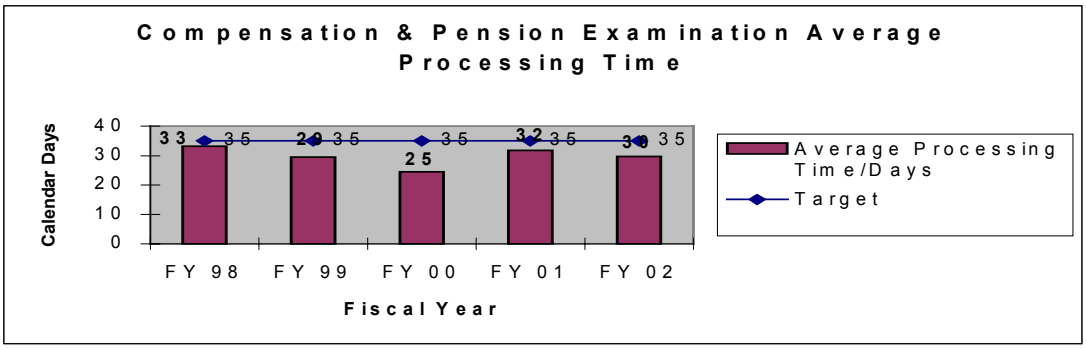


Figure 7.1-12 Processing of Compensation and Pension Exams

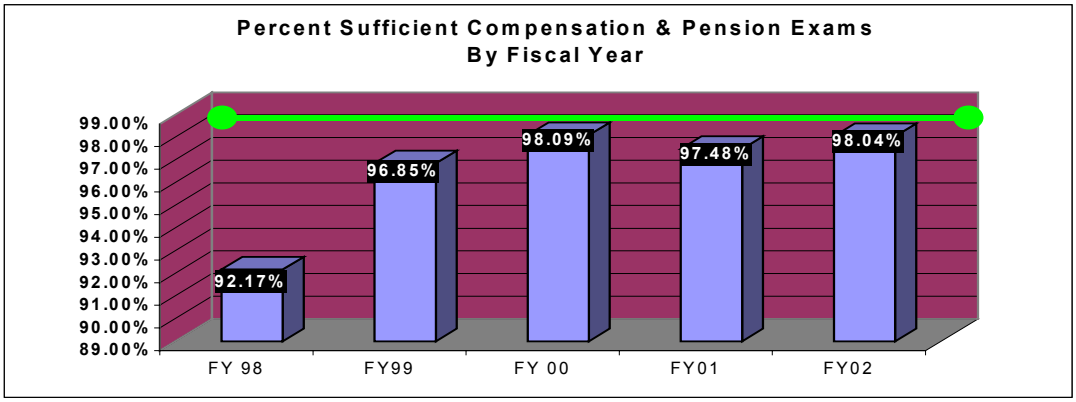


Figure 7.1-13 Percent Sufficient Compensation and Pension Exams

Accreditation by various organizations attests to the Medical Center's intent to meet or exceed the same standards set for the non-VA sector. Of particular note on recent surveys through the Commission on Accreditation of Rehabilitation facilities sited our Comprehensive Integrated Inpatient Rehabilitation Program and our Employment and Community Service – Healthcare for Homeless, with an exemplary performance for staff development program and operational leadership. This was a particularly high recognition as these were first time accreditation pursuits.

Accrediting Organization	Results
Joint Commission for Accreditation of Healthcare Organizations (JCAHO)	Full accreditation – score of 92(hospital), 93 (long term care), 100 (Sayre Outpatient Clinic laboratory), 96 (Home Care)
College of American Pathologists (CAP)	Full accreditation
American Association of Blood Banks (AABB)	Full accreditation
American College of Surgeons	Full accreditation
Tumor Registry	Full accreditation
Food and Drug Administration (FDA)	Full accreditation
Nuclear Regulatory Commission (NRC)	Full accreditation
Commission on Accreditation of Rehab Facilities-Comprehensive Integrated Inpatient Rehab Program	Full Accreditation/No Recommendations
Commission on Accreditation of Rehab Facilities-Employment and Community Service-Healthcare for Homeless	Full Accreditation/No Recommendations

Figure 7.1-14 Accreditations

7.2. Financial Performance Results -The obligations per unique patient measures the total expenditures divided by the total number of unique veterans, which has been consistently lower than network and national averages. For fiscal year 2002, obligations/patient totaled $3003, or 32% lower than the national average.

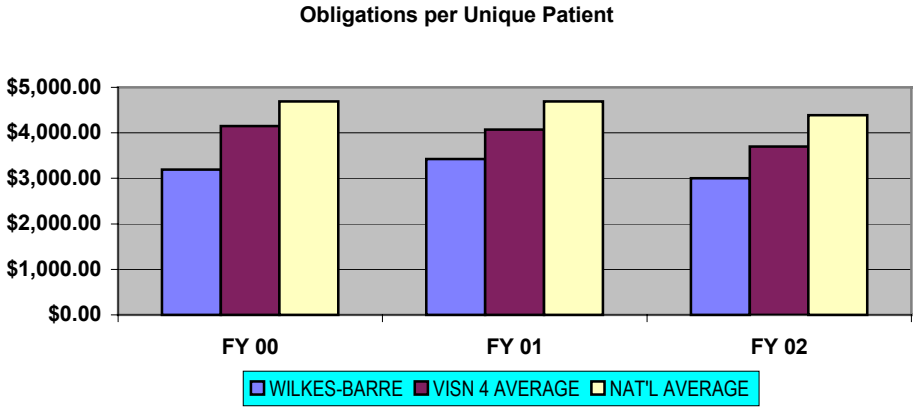


Figure 7.2-1 Obligations/Unique Patients-

The Medical Center receives reimbursement for health care services from insurance companies and patient co-payments through the medical care cost fund (MCCF) collections. Collections have increased by 64% this year.

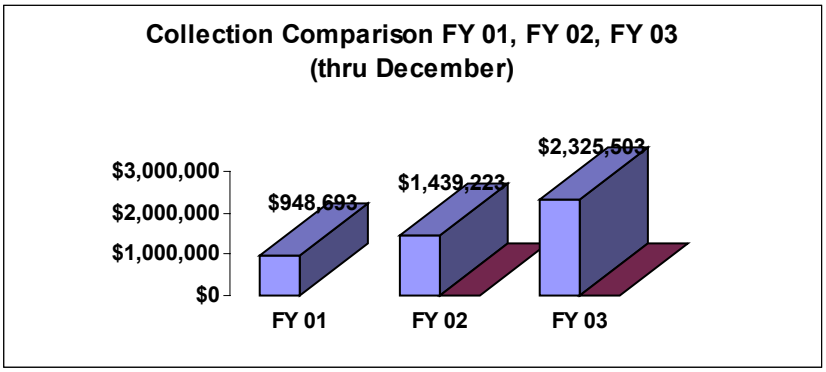


Figure 7..2-2 Obligations/Unique Patients

Pharmacy costs contribute to a major portion of the Medical Center budget. For that reason, numerous initiatives have been implemented to control these costs. A decrease in costs per prescription fill has been realized through a 90-day prescription fill policy. Decrease use of non-formulary prescriptions was another initiative that contributed to a 4.4 million cost savings in fiscal year 2002.

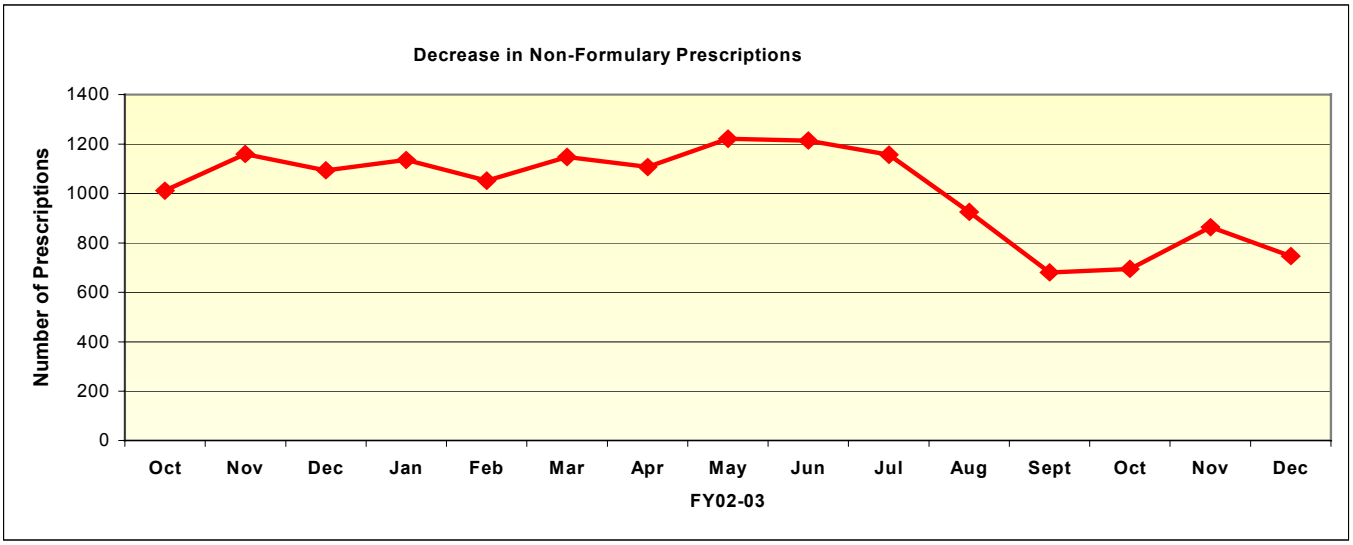


Figure 7.2-3 Non-Formulary Prescriptions

Centralized Mail-Out Pharmacy (CMOP) is another initiative employed to reduce pharmacy costs. The decrease in number of prescriptions is related to CMOP's stock-on-hand and 90-day prescription implementation.

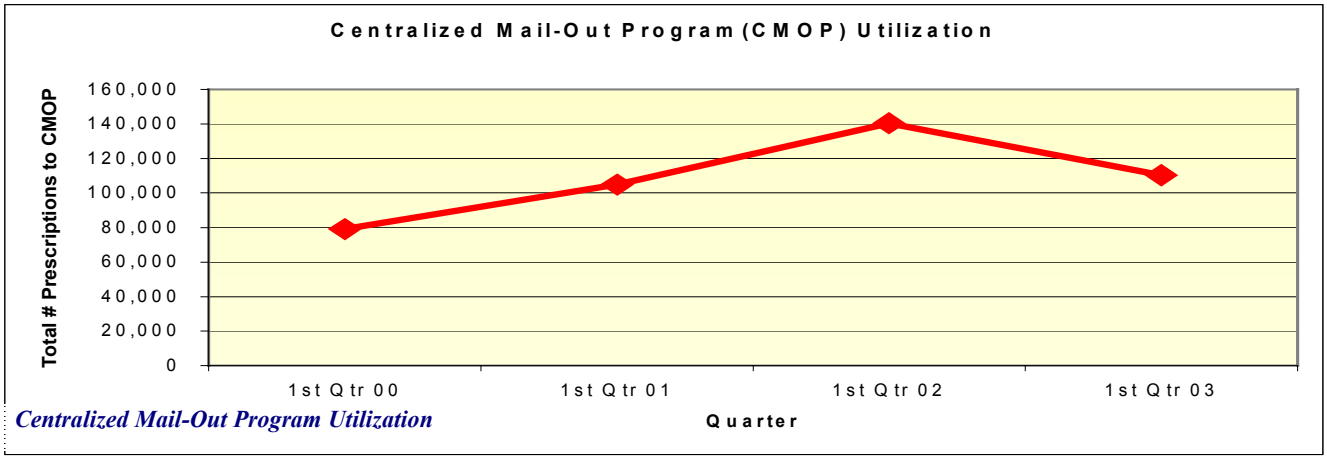


Figure 7.2-4 Centralized Mail-Out Program Utilization

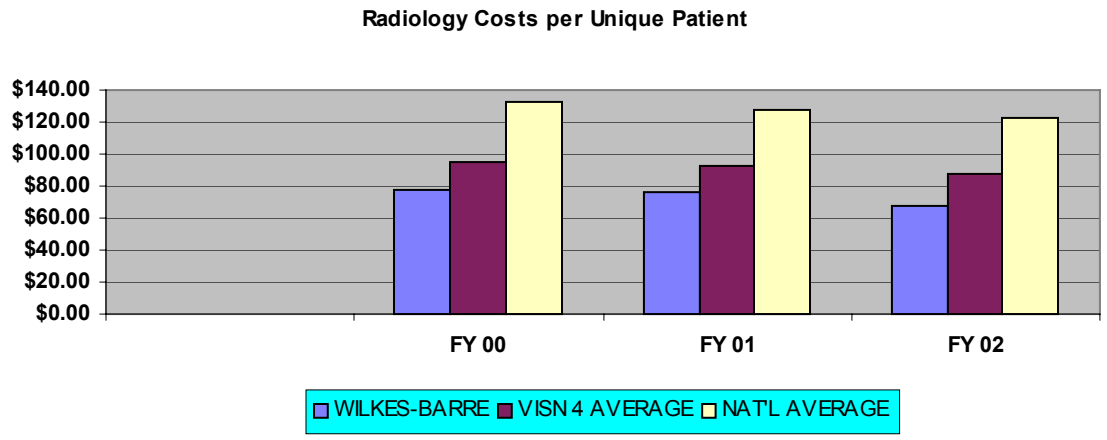


Figure 7.2-5 Radiology Costs/Per Unique Patient

This facility has consistently maintained costs per patient below Network and National averages in Laboratory and Radiology. This demonstrates increased efficiency without diminishing service.

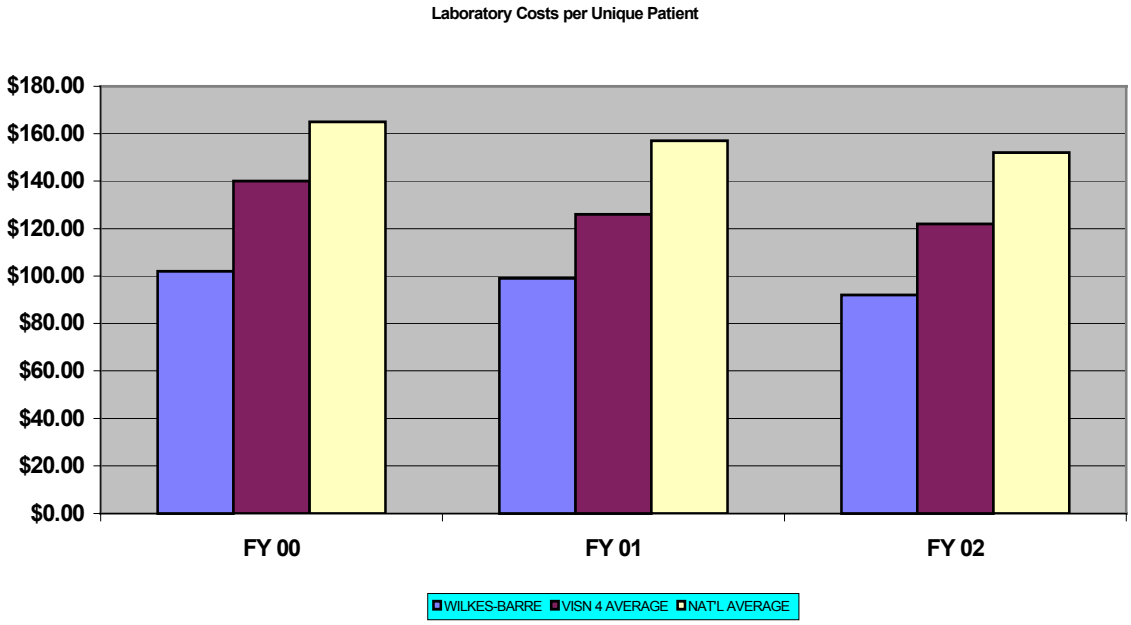


Figure7..2-6 LaboratoryCosts/Unique Patient

Inpatient care is most costly and generally the least preferred treatment alternative compared to outpatient care. Indicators of this shift from inpatient to outpatient care would include a decreased number of inpatients admissions, a decreased average inpatient daily census, and an increased number of outpatient visits. These measures for all treating specialties and locations consistently indicate this shift in resources helps us achieve our goal of increased access for our veteran patients.

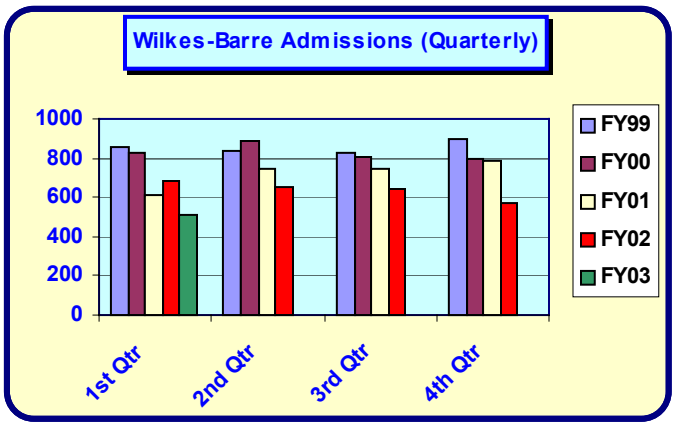


Figure 7.2-7 Admissions

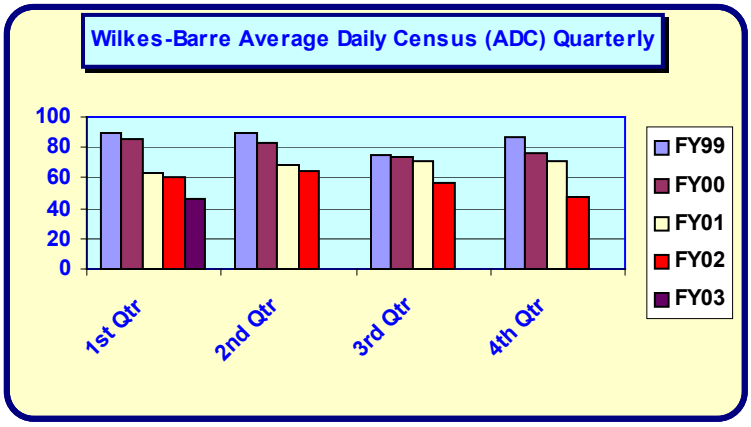
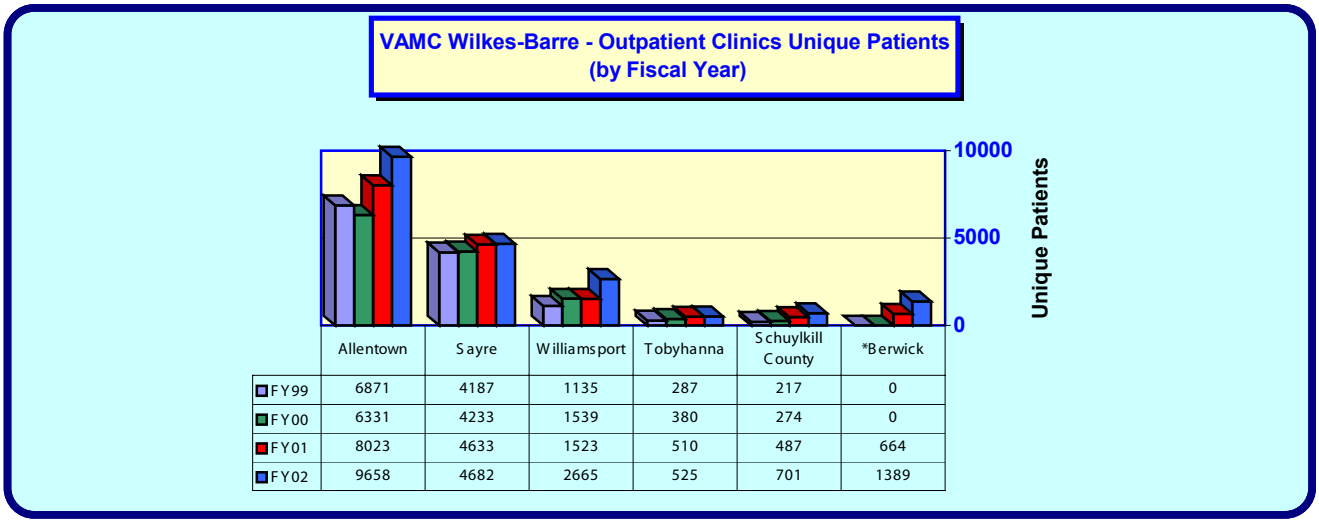


Figure 7.2-8 Average Daily Census



	Allentown	Sayre	Williamsport	Tobyhanna	Schuylkill County	*Berwick
FY99	6871	4187	1135	287	217	0
FY00	6331	4233	1539	380	274	0
FY01	8023	4633	1523	510	487	664
FY02	9658	4682	2665	525	701	1389

Figure 7.2-9 Outpatient Clinic Unique Patients

In the shifting from inpatient to outpatient treatment, easier access to care would have a positive impact. During the past few years, the number of access points have expanded and now includes a new clinic in Columbia County. In addition, as indicated in the graphs below, outpatient visits in the outreach areas have increased more significantly than at the main facility in Wilkes-Barre, which is a positive outcome.

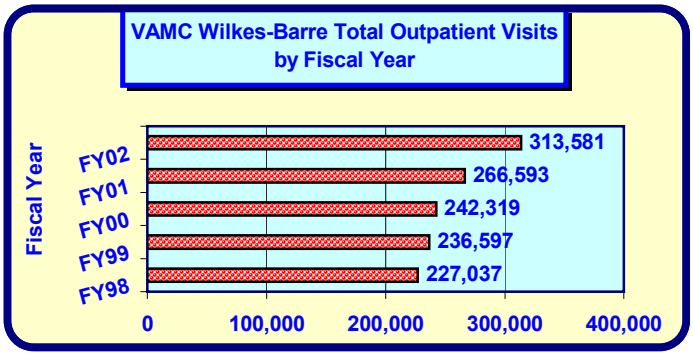


Figure 7.2-10 Outpatient Visits/

A reduction of Full-time Equivalent Employee (FTEE) has been realized through cross-training of staff, application of new technologies, redistribution of staff from areas of low workload to high workload, and realignment of services from inpatient to outpatient treatment areas. During this pas year, the number of clinical staff were increased to meet the rapidly growing demand for outpatient services.

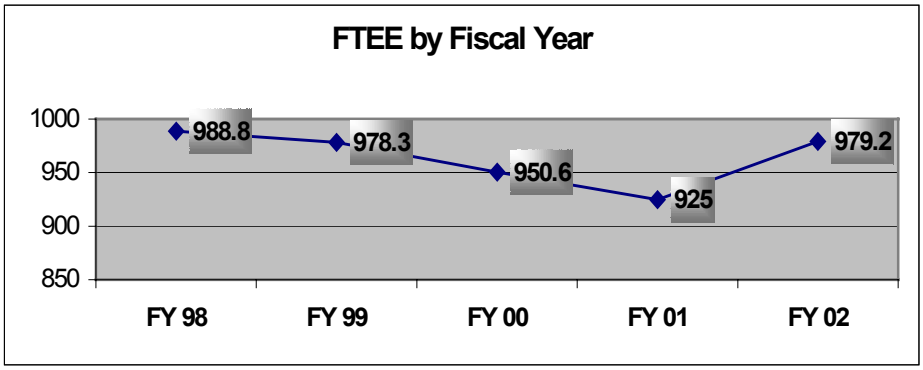


Figure 7.2-11 FTEE Staffing Lev

7.3 Human Resource Results – Employee satisfaction is promoted through career and educational opportunities, recognition, and safety initiatives. Numerous measures related to human resources results are in place. One of the Medical Center's performance measures requires a prescribed number of hours of continuing education and safety education per employee per year. The Medical Center has exceeded this measure. In addition, Figure 7.4-3 indicate positive employee perceptions of a safe work environment during a survey.

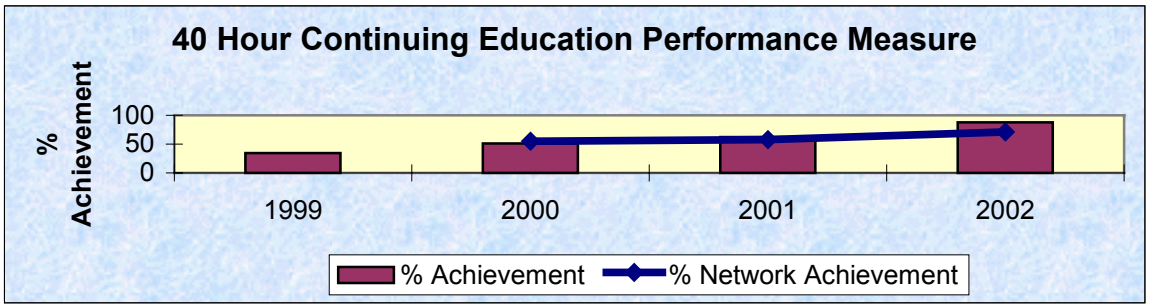


Figure 7.3-1 Education Hours

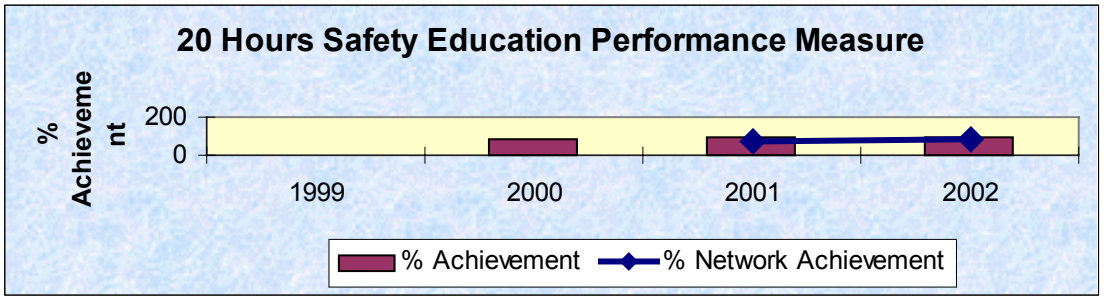


Figure 7.3-2 20 Hours Safety Education

Professional and personal growth are encouraged by investing Medical Center dollars in employee continuing education. Due to budgetary constraints, the facility needed to shift funds to meet patient care requirements.

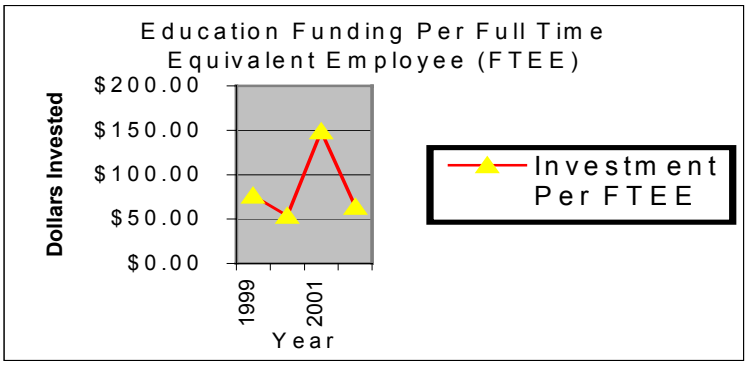


Figure 7.3-3 Education Funding/FTEE

One of the educational initiatives to build an effective organizational culture is the provision of Covey training to all Medical Center employees. The Covey principles encompass seven practices, or habits, that are linked to an individual's ability to demonstrate personal and professional relationship effectiveness and growth. Positive organizational culture change is expected as the number of employees who complete the program increases.

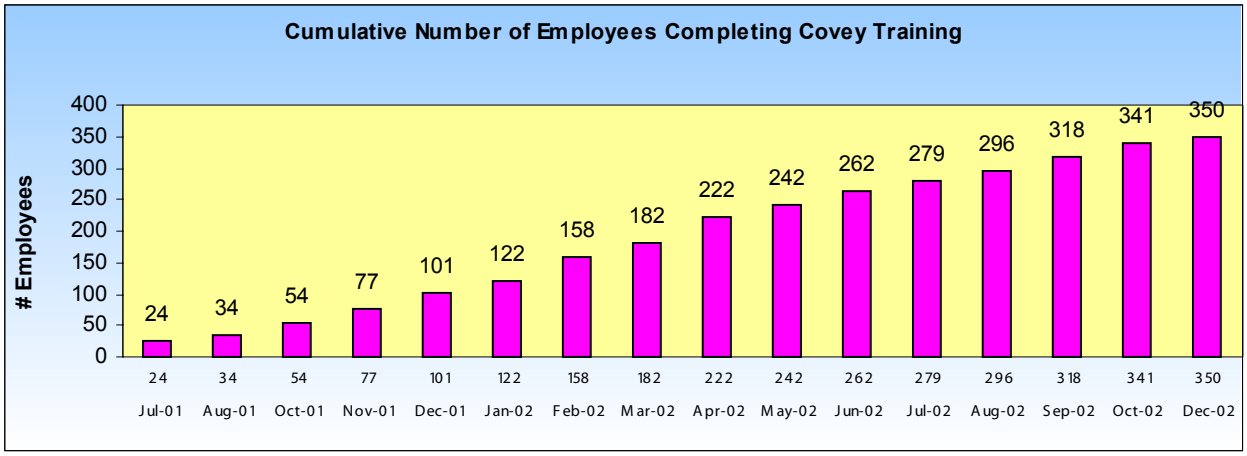


Figure 7.3-4 Employees Completing Covey Training

Incentive awards are used to honor achievements and contributions of individuals or workgroups. Employee recognition promotes a positive work environment that reinforces high performance.

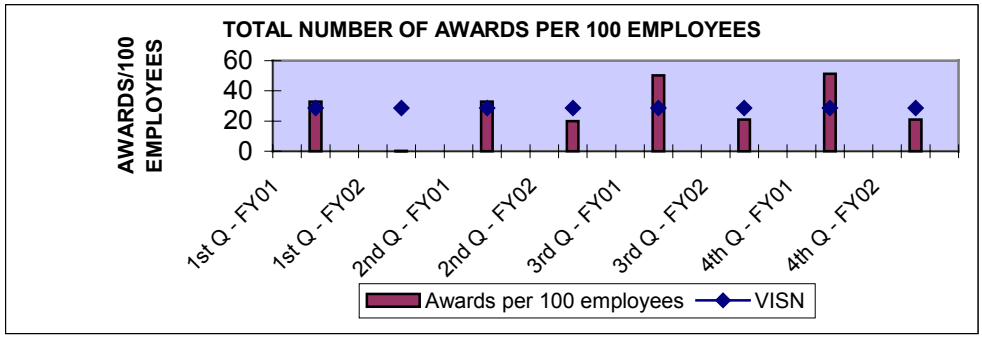
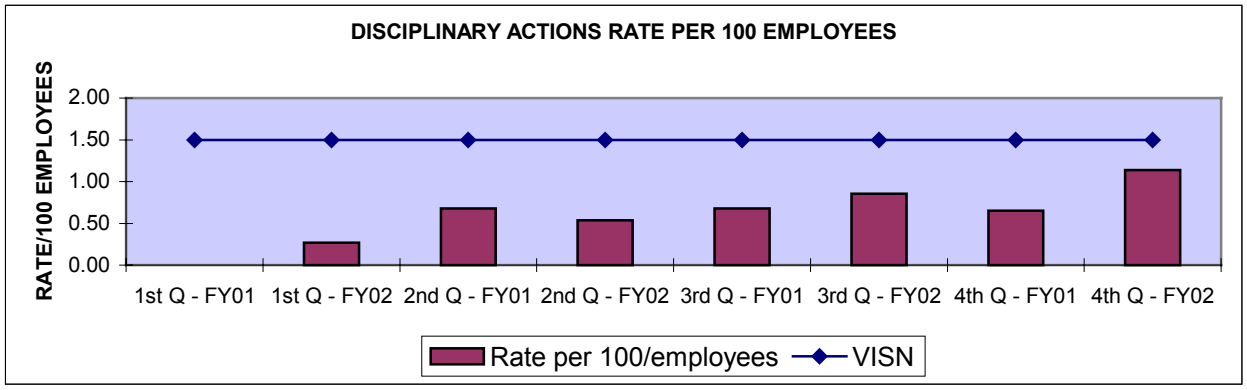


Figure 7.3-5 Incentive Awards



. *Figure 7.3-6 Disciplinary Action*

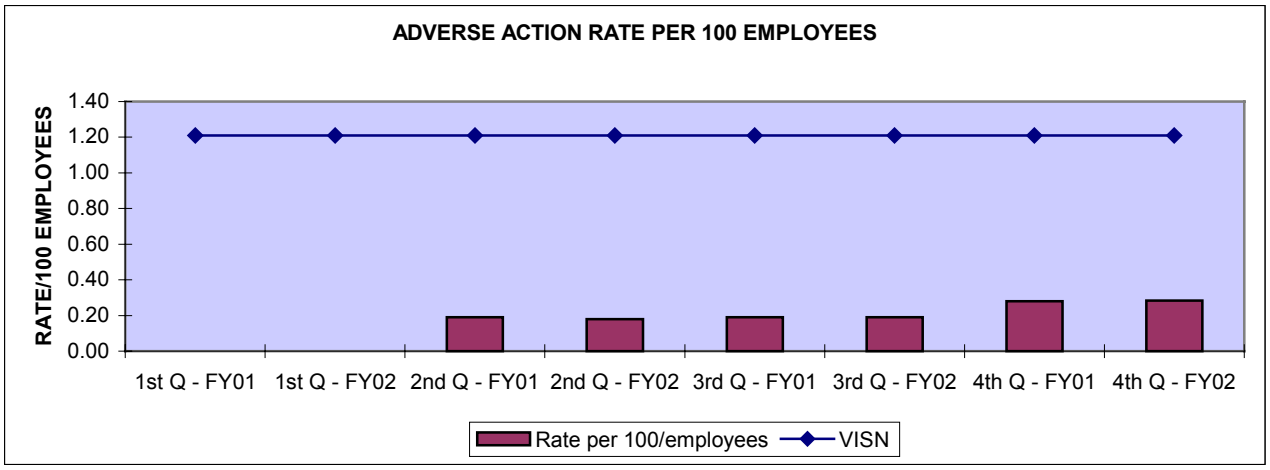


Figure 7.3-7 Adverse Actions

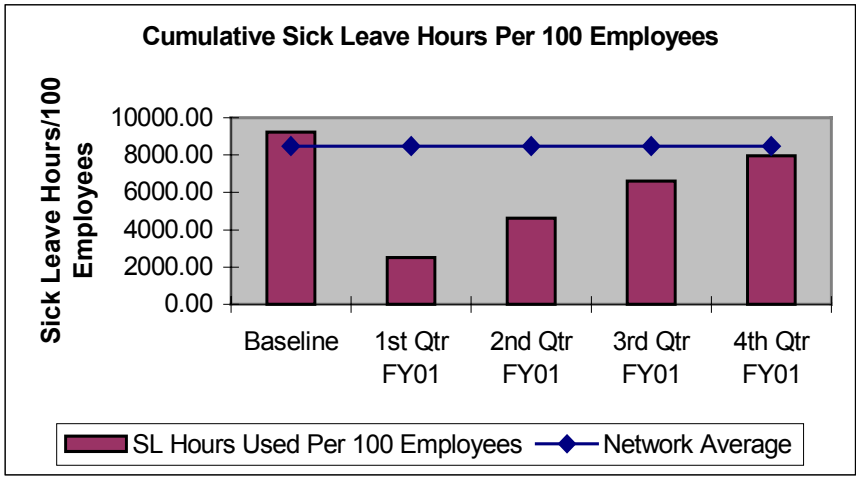


Figure 7.3-8 Cumulative Sick Leave Hours

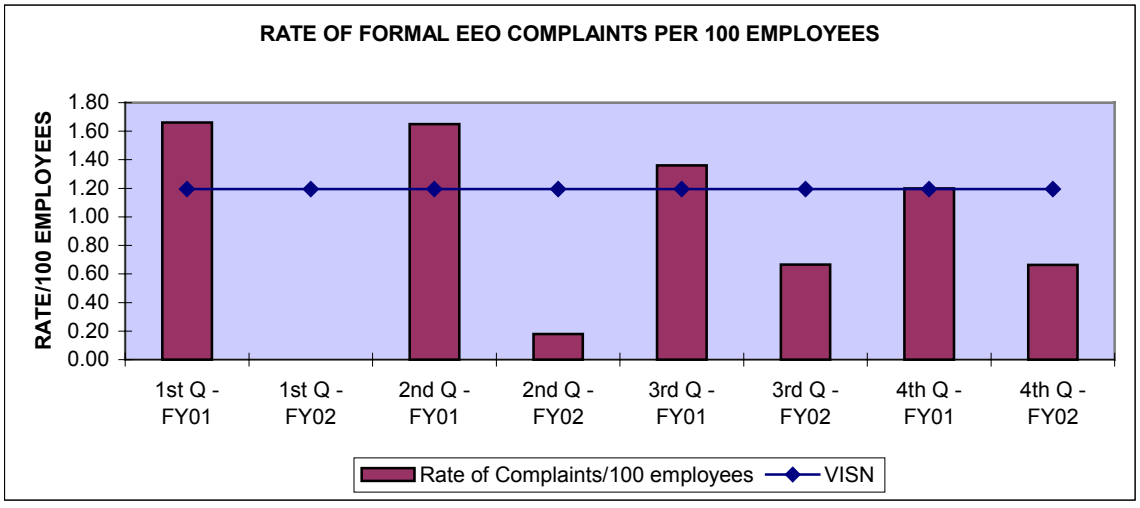


Figure 7.3-9 EEO Complaints

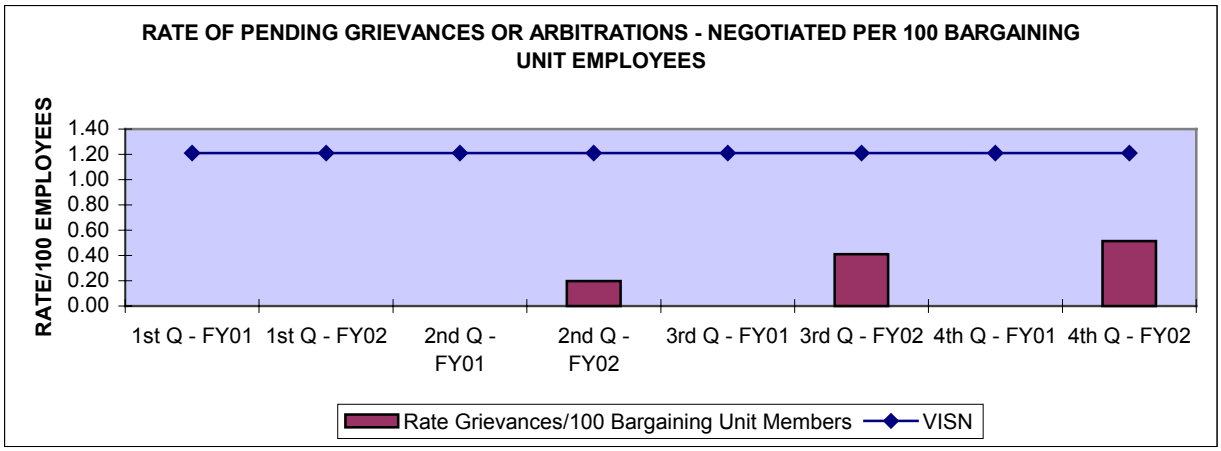


Figure 7.3-10 Unfair Labor Practices (None for this Period)

Mandatory education to all employees includes numerous topics such as ethical conduct and safety. Attendance rates of this annual program have increased.

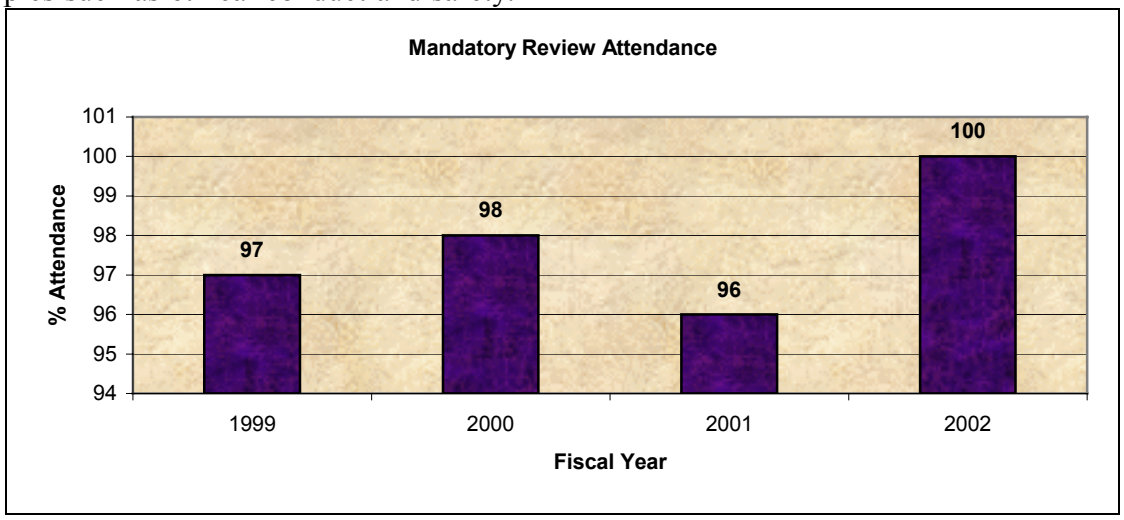


Figure 7.3-11 Mandatory /Continuing Education

Efforts to enhance employee safety and the implementation of a case management system have resulted in a reduction of employee lost time and Occupational & Workers' Compensation Program (OWCP) costs. With employee health intervention, the duration of lost time due to injuries decreased, thus minimizing costs.

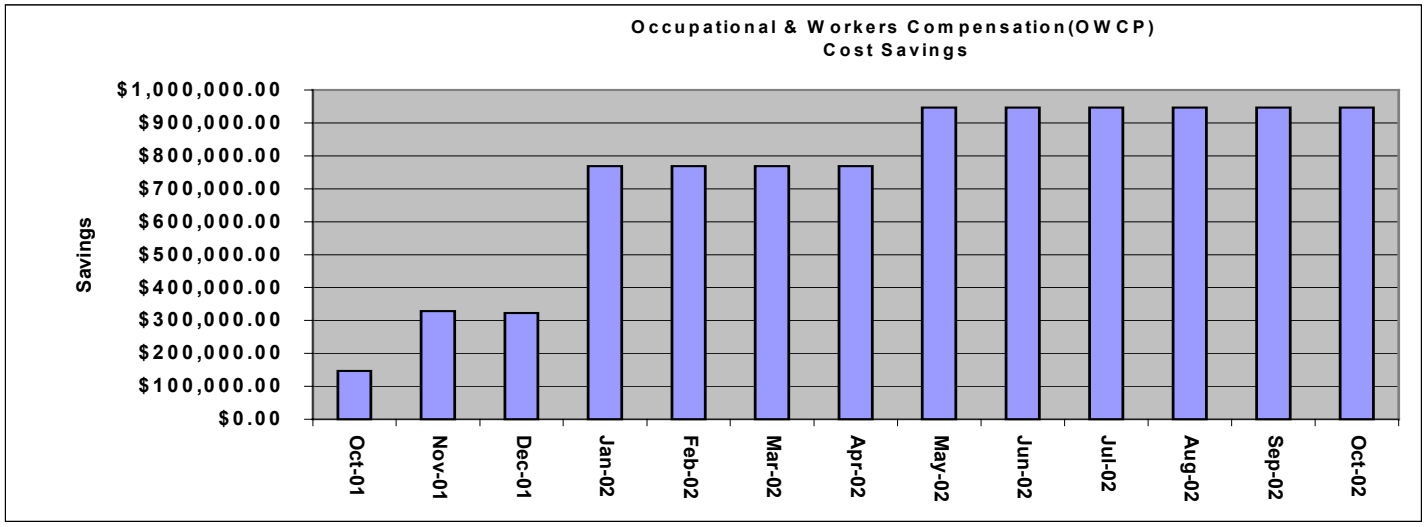


Figure 7.3-12 OWCP Cost Savings

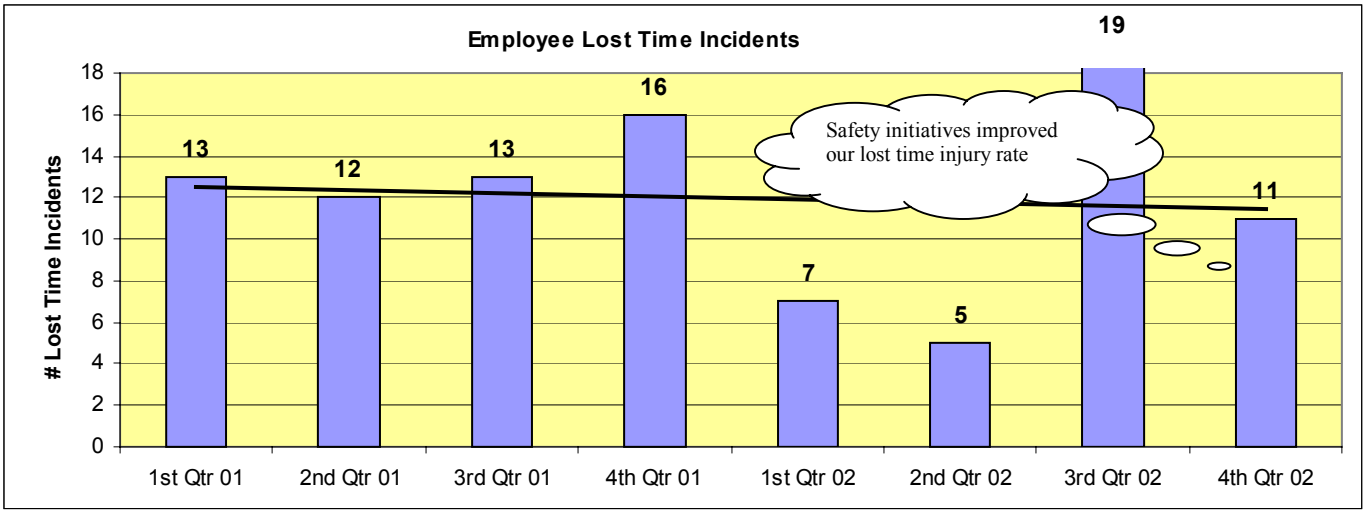


Figure 7.3-13 Employee Lost Time Incidents

The Federal government has a goal to employ persons with disabilities. This Medical Center's average exceeds the Network and national average of employing persons with disabilities because of affirmative strategies to recruit, retain, and advance persons with disabilities.

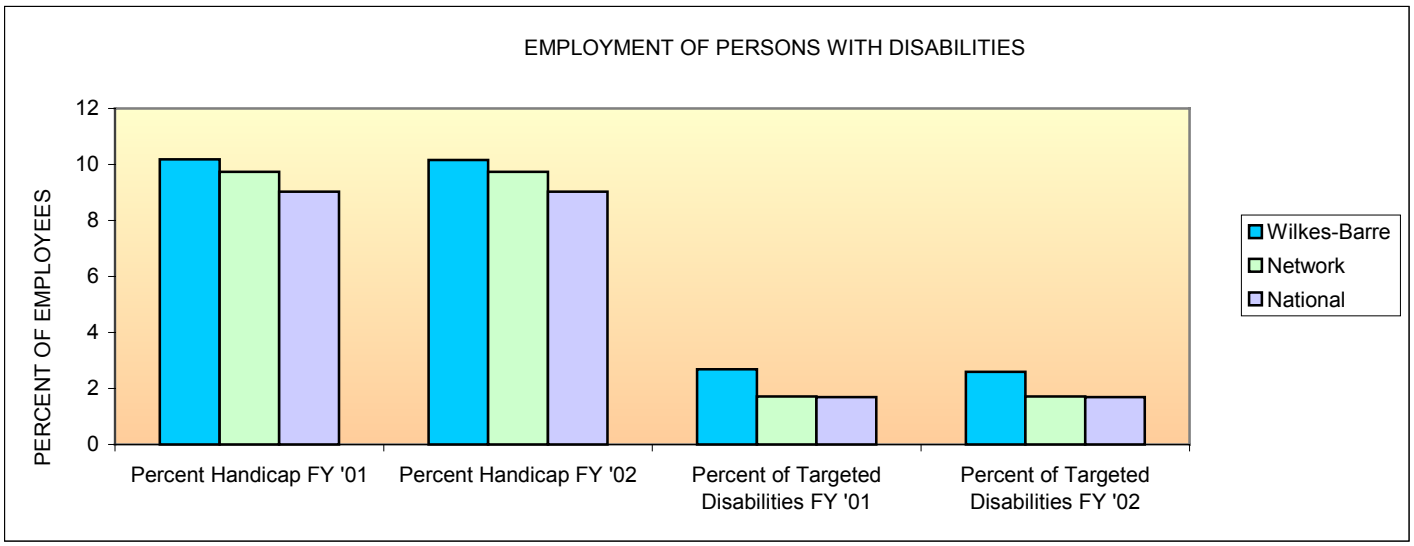


Figure 7.3-14 Employment of Persons with Disabilities

7.4 Organizational Effectiveness Results – 7.4.a. Operational Results – 7.4.a.(1) Health Care Service Reaults – The Medical Center tracks multiple clinical performance measures, benchmarks the results against other VA Medical Centers nationwide, and continually strives to achieve established targets. Clinical practice guidelines and Prevention Index are measured by the External Peer Review Program (EPRP), which includes VA and private sector hospitals nationally. We recognize the established targets. These measures involve goals for both treatment and prevention of disease. Since the inception of these measures, performance has consistently improved. Recognizing that we needed to provide a consistent approach to ensure conformity to address the areas identified we included this specific information in the patient initial assessment template, and offered clinical reminders in the electronic medical record.

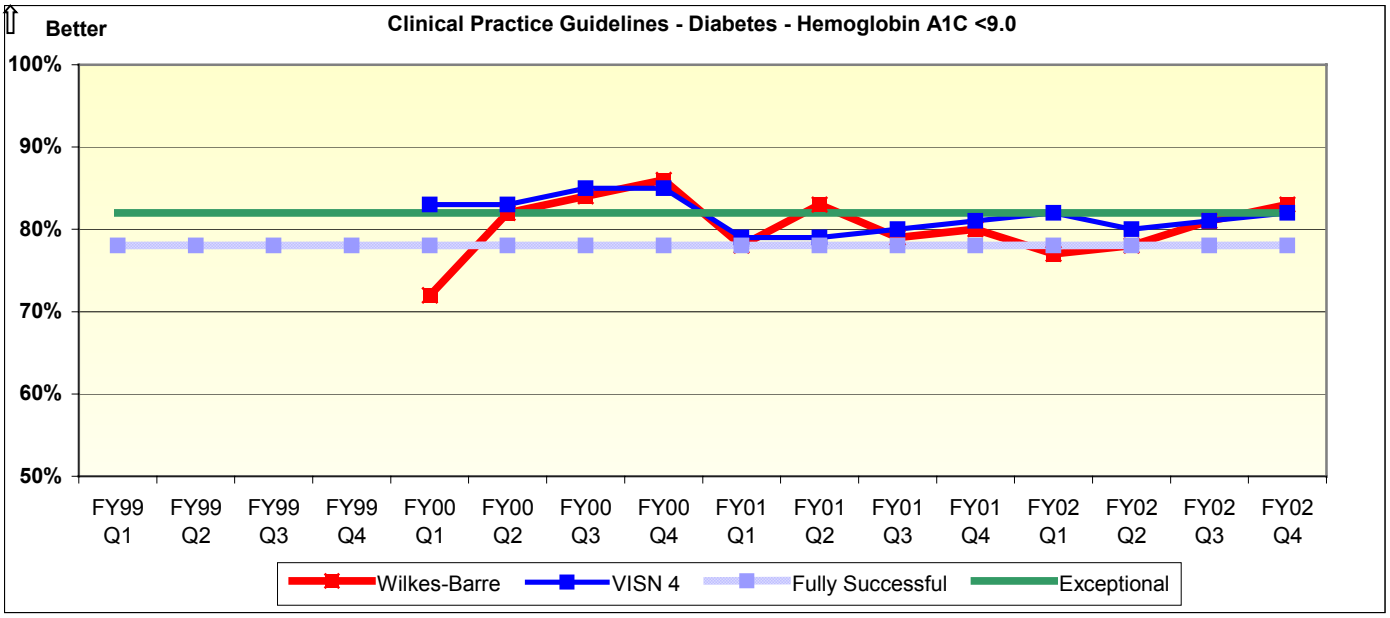


Figure 7.4-1Clinical Practice Guidelines –Diabetes –Hemoglobin A1C

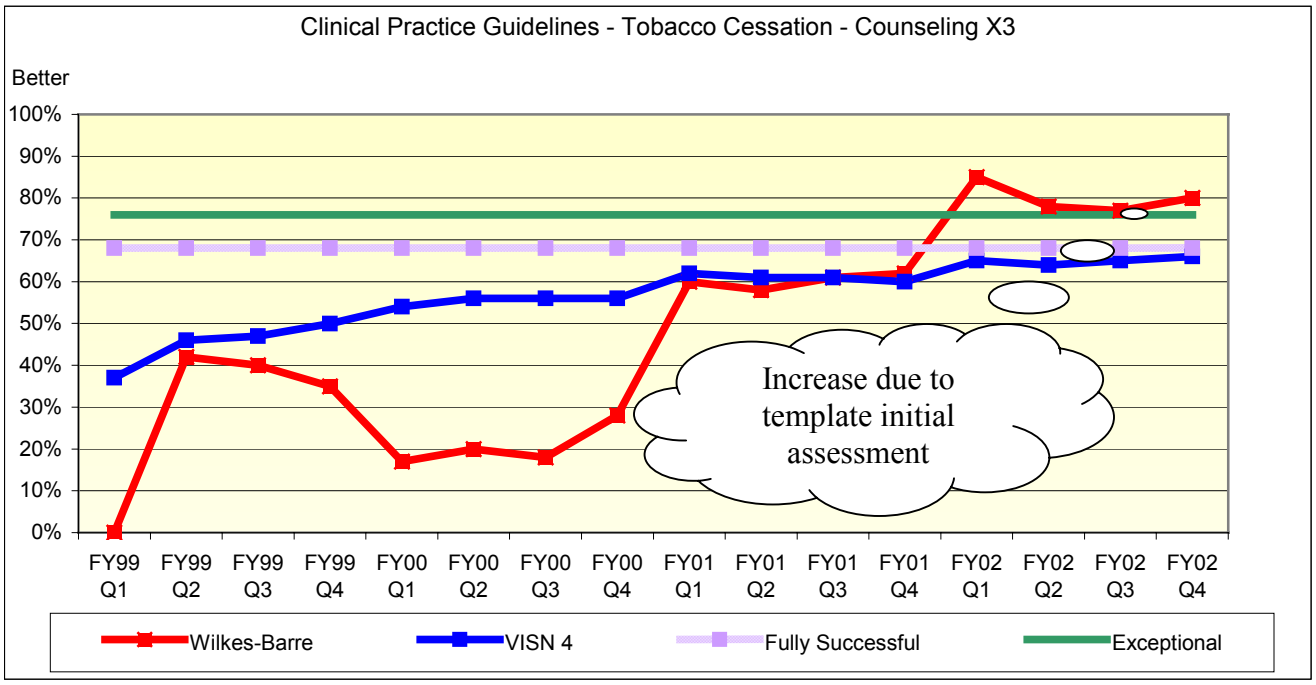


Figure 7.4-2 Clinical Practice Guidelines –Tobacco Cessation –Counseling

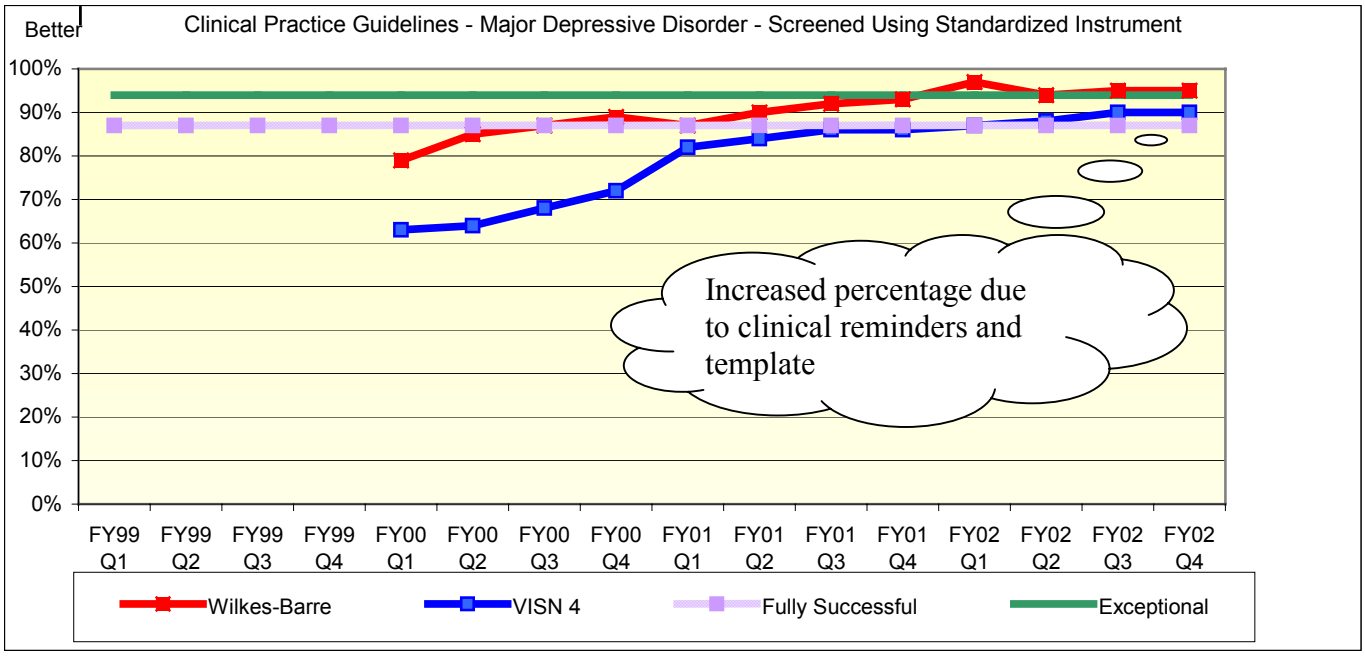


Figure 7.4-3 Clinical Practice Guidelines –Major Depressive Disorder

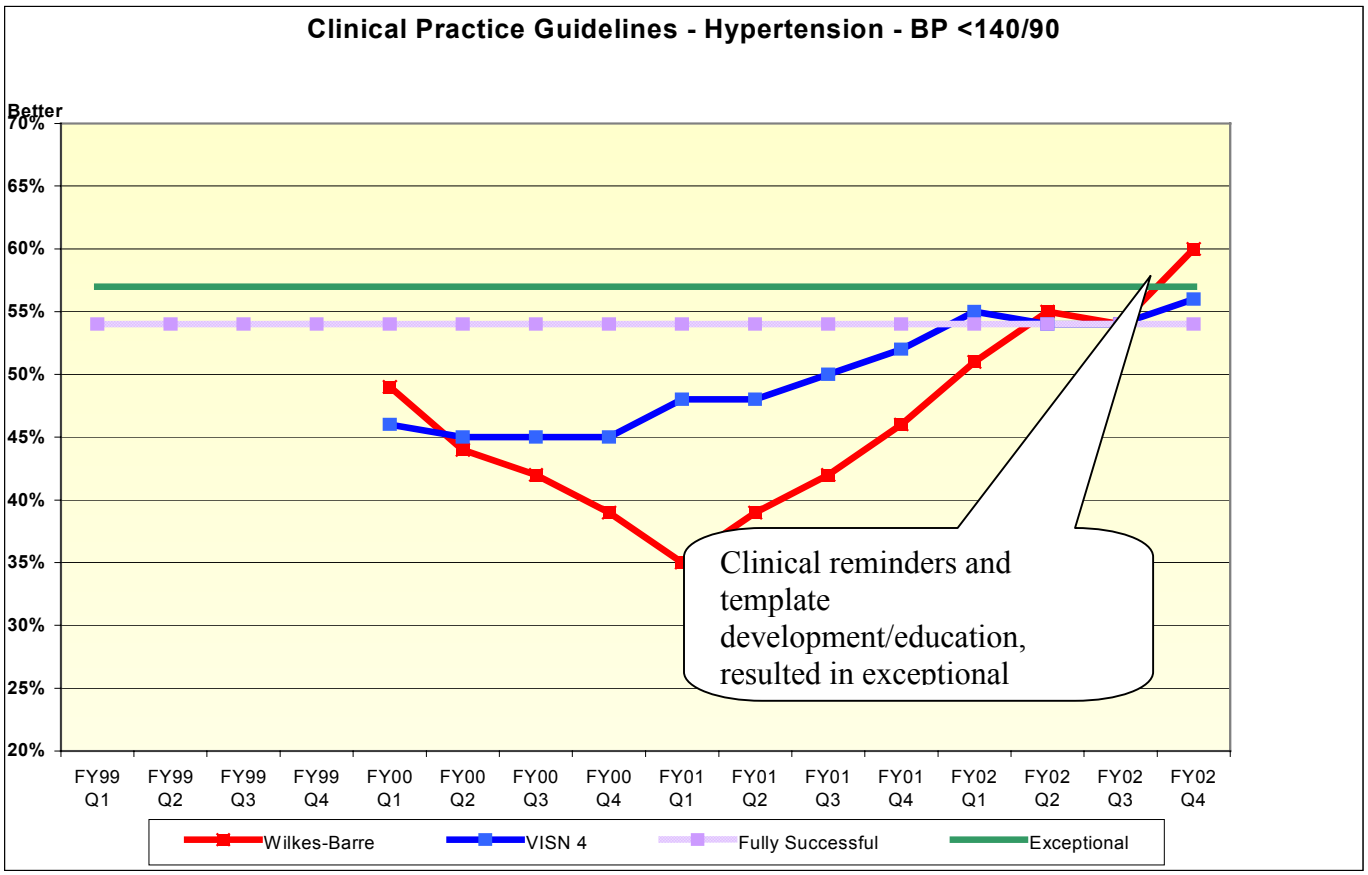


Figure 7.4-4 Clinical Practice Guidelines –Hypertensionr

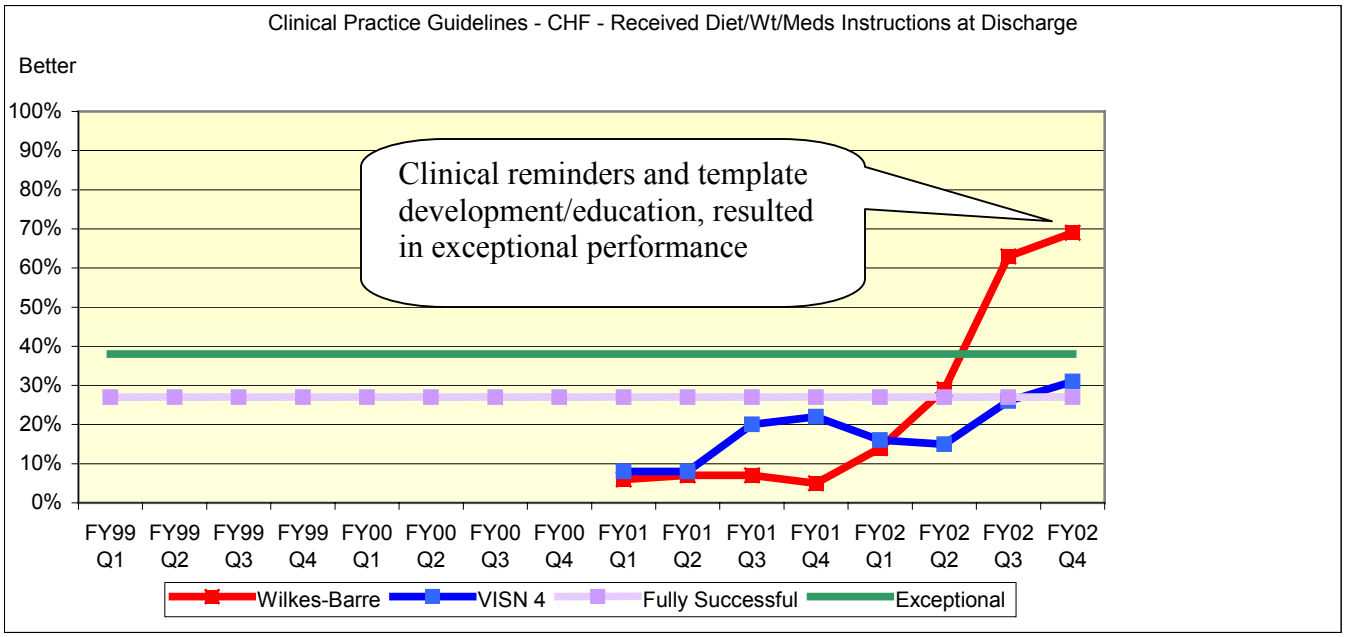


Figure 7.4-5 Clinical Practice Guidelines –Congestive Heart Failure

The National Surgical Quality Improvement Program (NSQIP) was created to measure and report comparative risk-adjusted mortality and morbidity to all peer-related and national Veteran Affairs Medical Centers performing major surgery. The NSQIP is utilized to track and ensure quality surgical care to our veterans. Wilkes-Barre VAMC has received "Commendation for all non-cardiac surgery" by the NSQIP for a low outlier status in post-operative mortality and risk-adjusted outcomes have remained consistently below the national average.

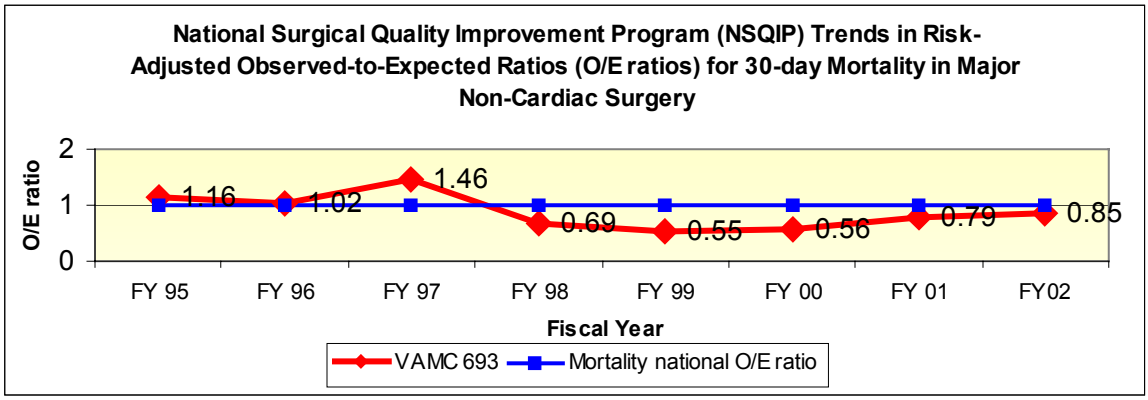


Figure 7.4-6 NSQIP Mortality: Major Non-Cardiac Surgery

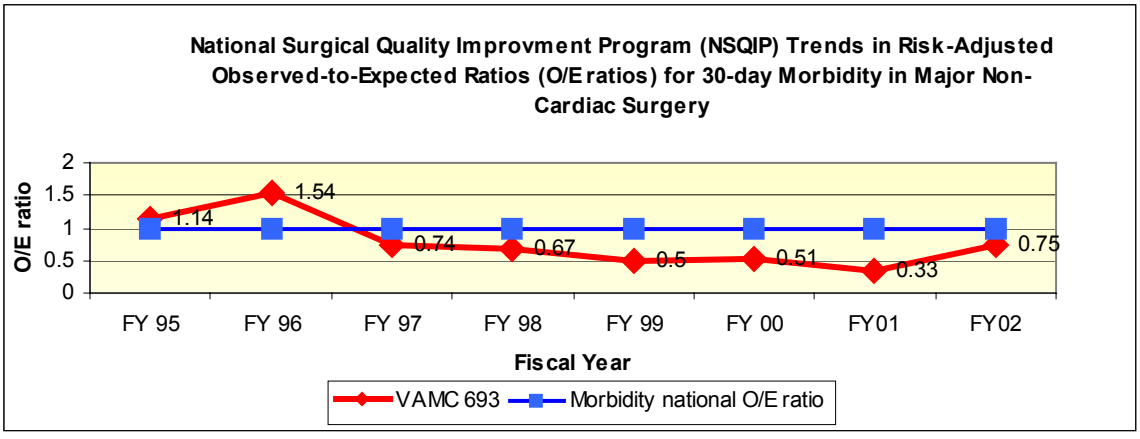


Figure 7.4-7 NSQIP – Morbidity: Major Non-Cardiac Surgery

Trending of patient incident reports involving falls in the Nursing Home Care Unit spawned the creation of an action group. This group initiated several actions that resulted in dramatic reductions. These initiatives included low-rise beds, chair and bed alarms, floor mats, "Hipsters", patient safety posters at bedside, and room assessments to determine potential hazards. Through the National Falls Collaborative, additional interventional measures included implementation of Morse Scale, environmental assessments, poly pharmacy review, frequent fallers identification, and toileting interventions such as a bladder training program.

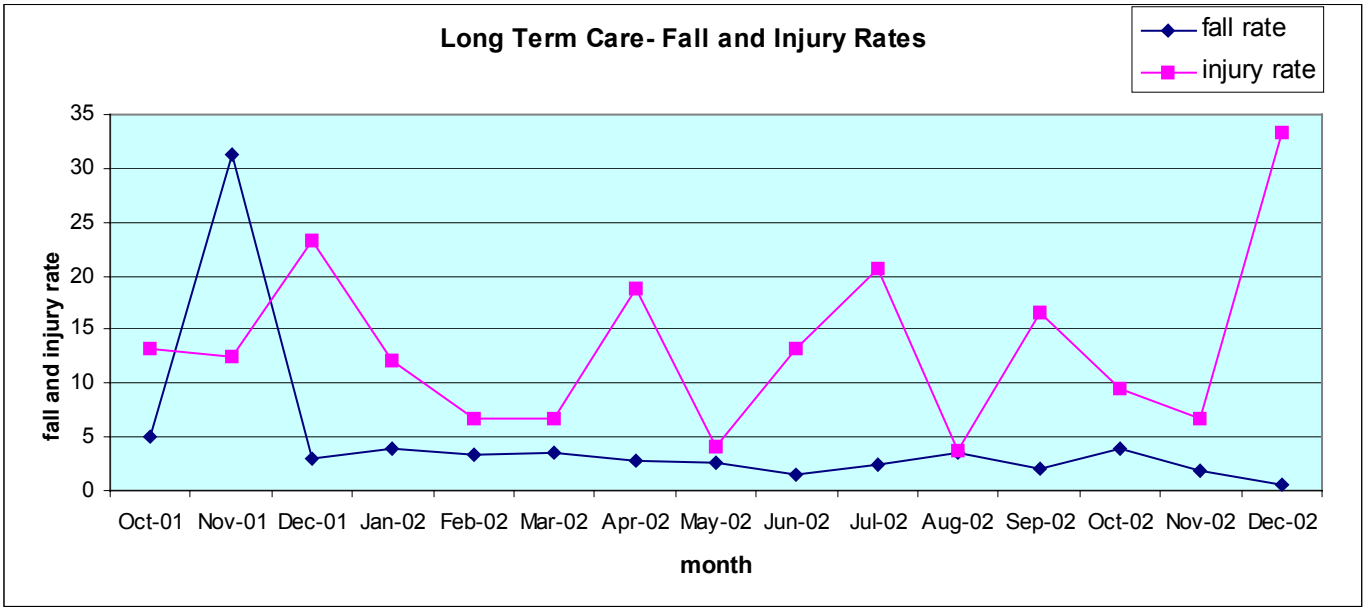


Figure 7.4 –8 Long Term Care-Fall and Injury Rates

Achievement of a restraint free environment is evident in both acute and long-term care environments. Safety device restraint usage has reduced dramatically due to the implementation of alternative measures such assignment of sitters and the utilization of occupational therapy services for diversional activities.

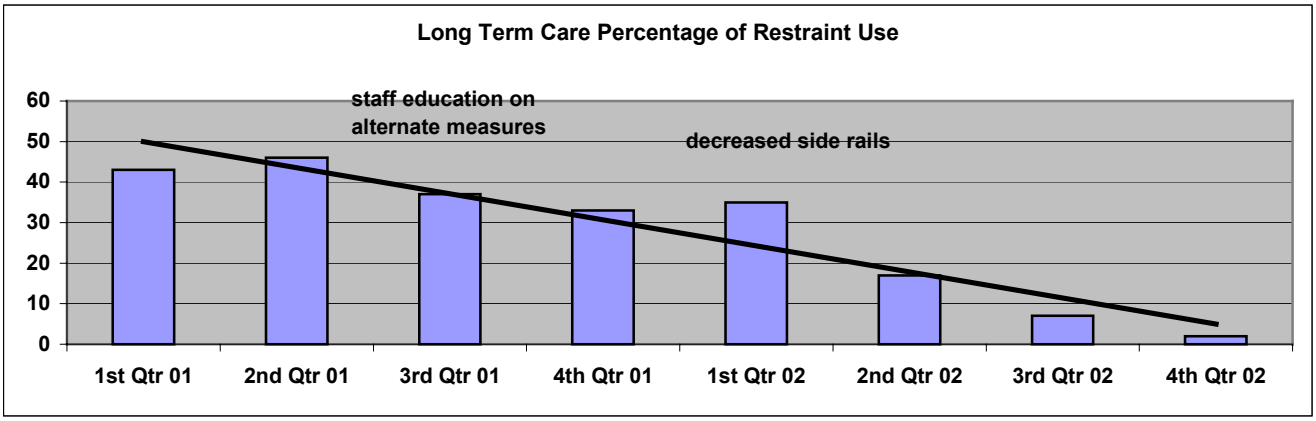


Figure 7.4-9 NHCU Safety Device Usage

Nosocomial incident rates of pressure ulcers per 1000 Bed Days of Care (BDOC) in the medical-surgical units have consistently declined due to the efforts of the interdisciplinary skin care team, which include weekly rounding, early intervention and continuous monitoring.

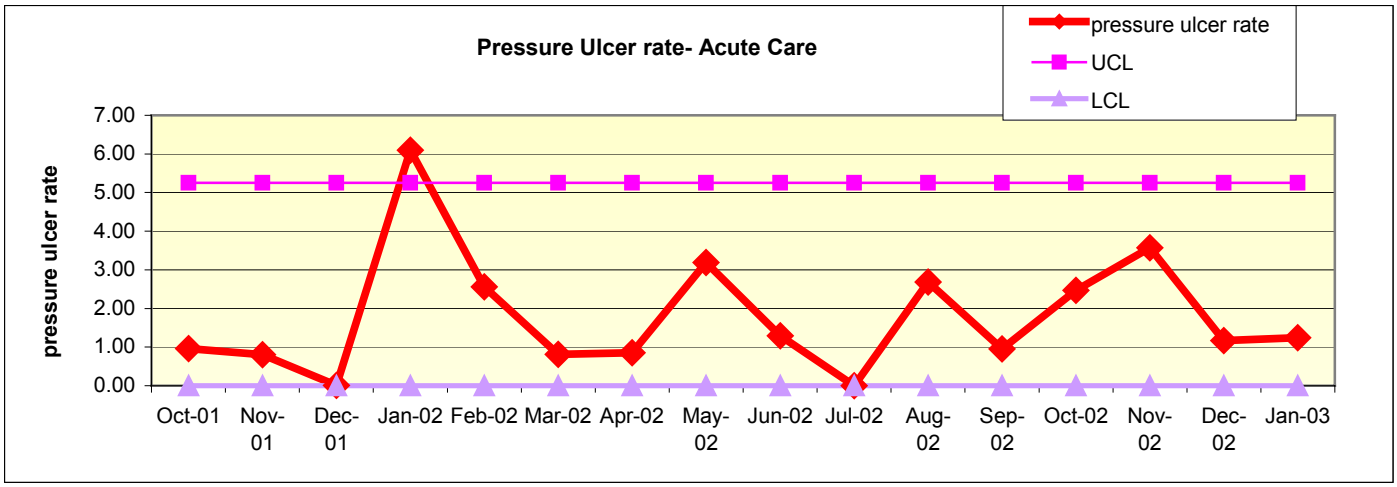


Figure 7.4-10 Pressure Ulcer Rate

7.4.a.(2) – Organizational Effectiveness Results - The waits and delays initiative uses a measure that has a predetermined time indicated for appropriate response to appointment requests for specialty services. WBVAMC meets the performance measure through innovative efforts which have been implemented to meet these requirements and reduce waiting times significantly each year. Data extracted from Balanced Scorecard is in Figure 1.3.

An example of successful deployment of strategies to reduce waiting time highlights the efforts of audiology services. Despite eligibility reform, which created an increased demand for services, the audiology department was able to dramatically reduce waiting time by a change in process, clinic profiling, and redistribution of staff. The result was a better than private sector and national Veterans Health Administration (VHA) standards for access to care.

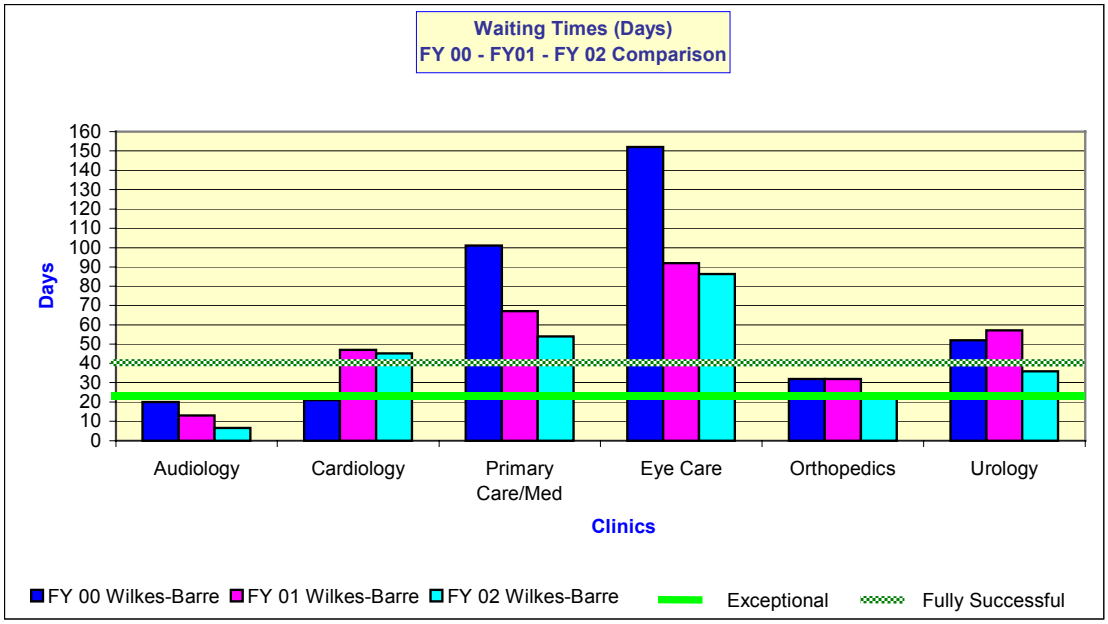


Figure 7.4-11 Waiting Times (Days)

Congress has mandated that a veterans prosthetic order should not be delayed for any reason, including insufficient funds, staffing shortages, pending administrative processing, excessive workload etc…In FY02 Wilkes-Barre VAMC processed approximately 3600 orders quarterly without a delayed order

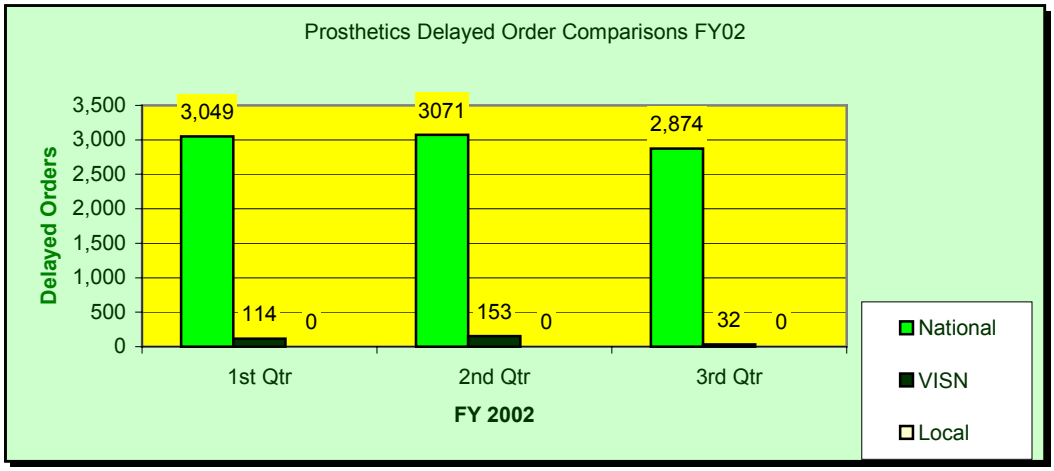


Figure 7.4-12 Prosthetics Delayed Order Comparisons

This facility has consistently maintained costs per patient below Network and National averages in Laboratory and Radiology. This demonstrates increased efficiency without diminishing service (Figures 7.2-5 and 7.2-6).

Timeliness for provision of clinical support services enhances primary care and specialty services. Timeliness of these services also impacts on customer satisfaction. Imaging services measures turnaround time for preparation of reports following imaging procedures in an effort to identify areas of improvement.

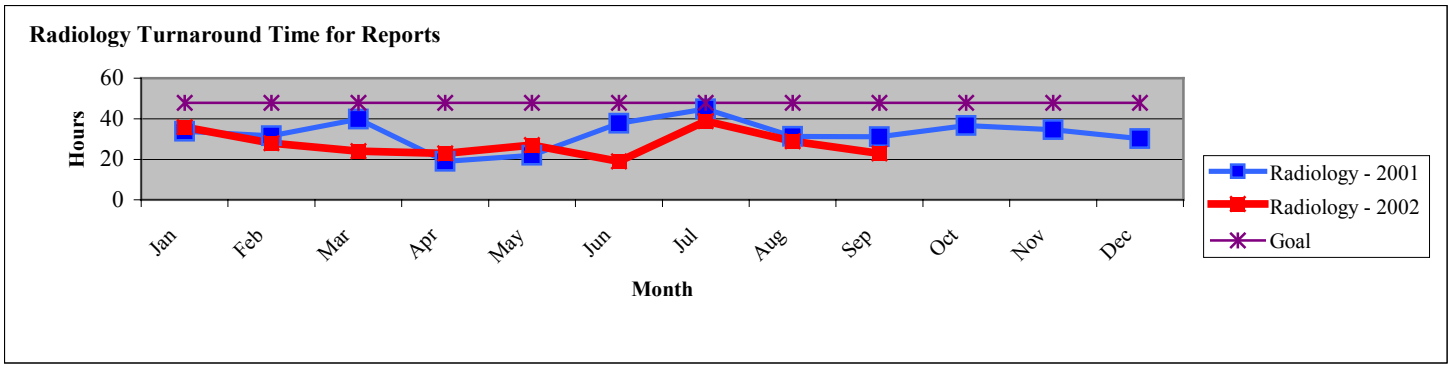


Figure 7.4-13 Radiology Turnaround Times

As a new VA initiative, the Medical Center's investment in new technology is evidenced by the increase in personal computers and internet access devices. This technology enhances intra-and inter-organizational effectiveness. This past year, the medical center initiated an intranet site and web page.

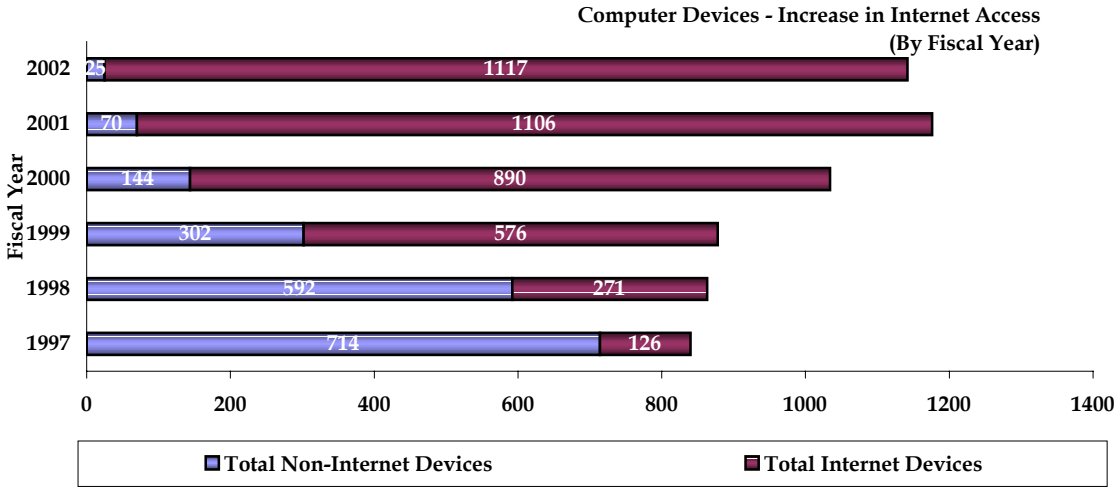


Figure 7.4-14 Computer Devices – (Internet Access)

7.4.b. Public Responsibility and Citizenshp Results – Accreditation by various organizations attests to the Medical Center's intent to meet or exceed the same standards set for the non-VA sector (Figure 7.1-14).

The organization maintains a high number of volunteer hours considering the challenges of a declining volunteer population base. Fiscal Year 2002 was marked by illness and death in the ranks of several of Voluntary Service's most productive volunteers – volunteers who served prominently in highly visible assignments. Other factors that occurred during the past year which negatively impacted the volunteer hours were: 1) Inception of a Compensated Work Therapy Program at the facility, which decreased the need for volunteers, especially in the Student Program; 2) Closing one floor of the Nursing Home Care Unit (60 beds) for renovation; 3) Condition of veteran patients requiring more afternoon activities when younger groups are working; 4) Loss of larger activities, e.g. Disabled American Veterans Auxiliary's Saturday Morning Coffee Hour, band and choral concerts, etc., due to the condition of the patients; 5) Loss of several organizations due to loss of charters and local post chapters.

An action plan was developed to increase the volunteer hours and stay focused on patients' needs. The action plan includes revamping our Staff Advisory Committee and a brainstorming meeting with recreational and occupational therapists for input regarding group activities that will benefit patients and provide volunteer hours for the program. The Voluntary Service Specialist will initiate recruitment efforts to accommodate suggestions received from the meetings. The Voluntary Service Officer also initiated a new program to increase volunteer hours and activities– "3 in 2003"; whereby, each service organization will provide 3 new volunteers; 3 new activities/assignments and assist in attracting 3 new corporations.

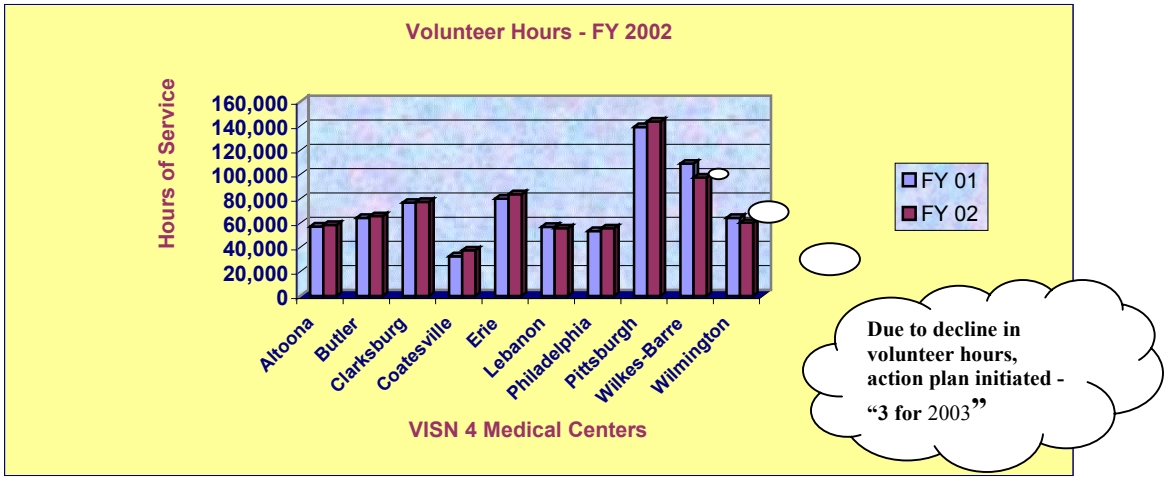


Figure 7.4-15 Volunteer Hours

The success of the Combined Federal Campaign, a charitable subsidiary of the United Way, demonstrates the Medical Center's commitment to support the community. Despite declining number of employees, donations to the campaign increased.

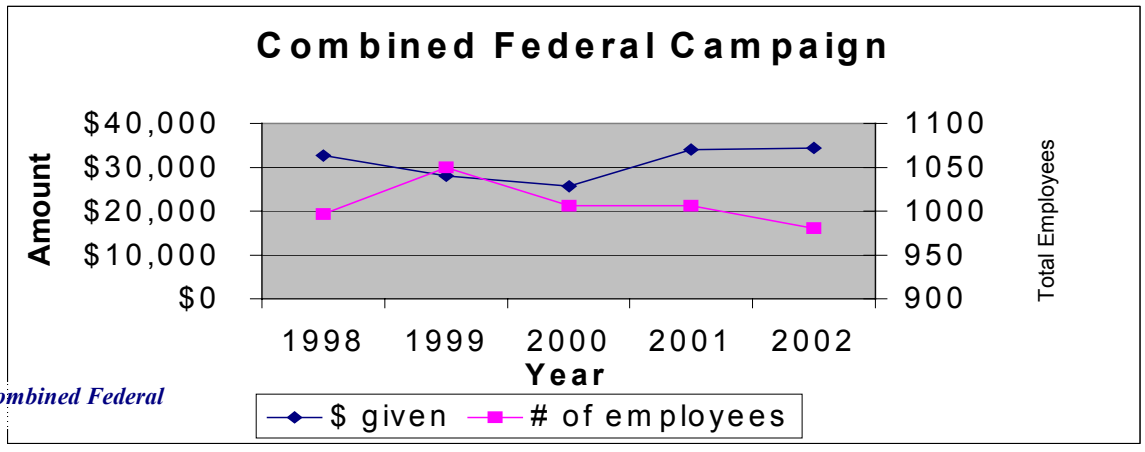


Figure 7.4-16 Combined Federal Campaign

The Medical Center actively supports the efforts of the American Red Cross by offering the facility as a donation center for quarterly blood donations. Employee participation in this effort was rallied by labor-management partnership incentives.

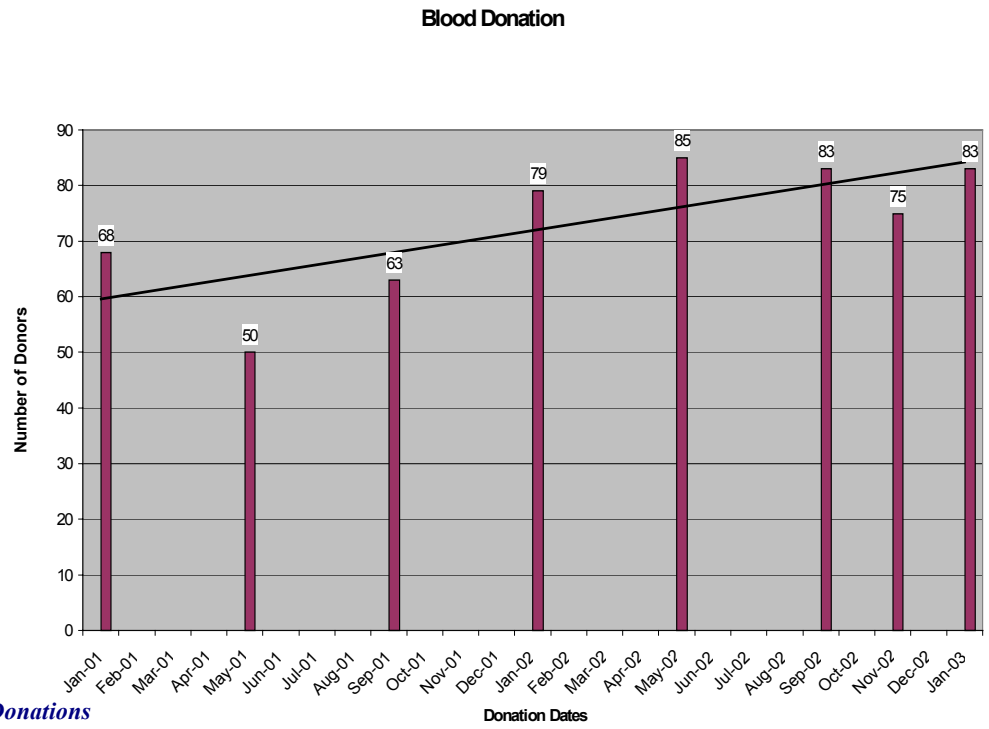


Figure 7.4-17 Blood Donations

Credit card usage is a federal law mandated for all agencies to meet a 99% rate of compliance. Credit cards are a procurement and payment mechanism designed to provide better financial and case management controls over federal procurement. The benefits include streamlined payment procedures; decreased administrative costs, provision of procedural checks, and feedback to improve management control and decision-making.

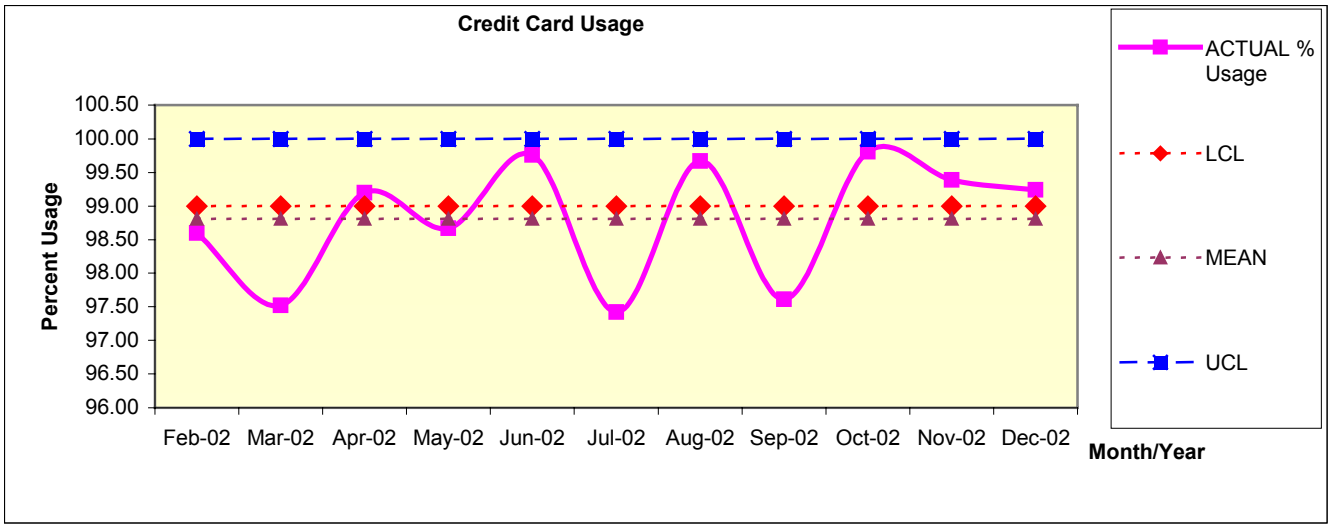


Figure 7.4-18 Credit Card Usage

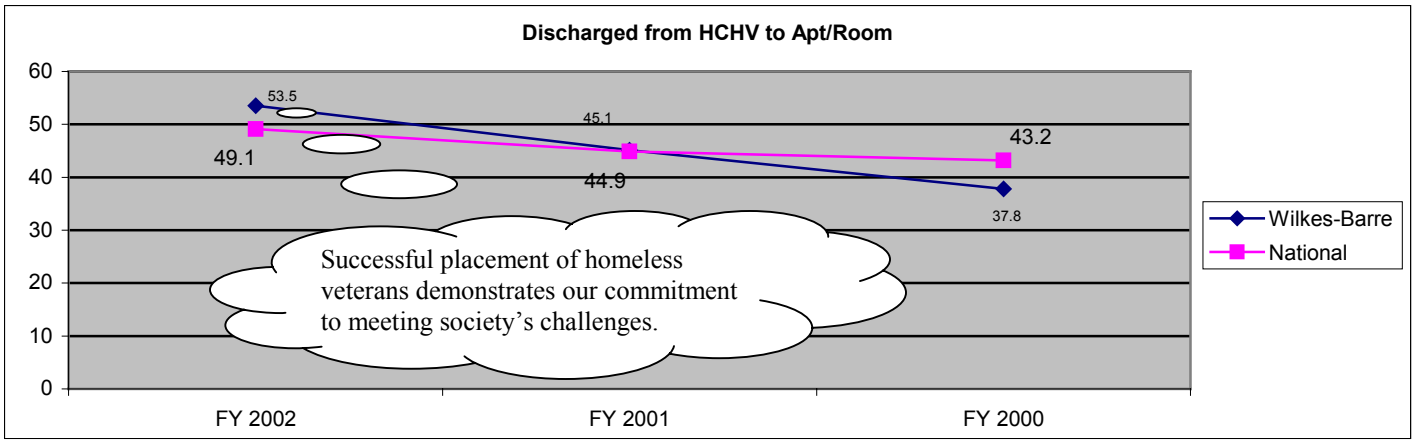


Figure 7.4-19 Discharged from HCHV to Apt./Room

The medical center strives to meet all compliance and regulatory requirements. Employee education plays a role in helping to achieve the various objectives of the compliance program. This facility has exceeded the network compliance education requirement.

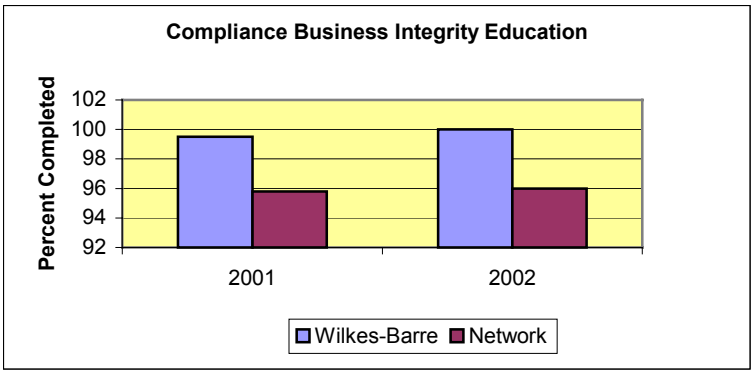


Figure 7.4-20 Compliance Business Integrity Education

The Medical Center, in an effort to improve the efficiency of the referral process to the Rehabilitation Unit, the Rehab Technical Advisory Group identified the largest referral source and surveyed internal stakeholders to seek information on methods to improve the process and promote access to the Rehabilitation Services.

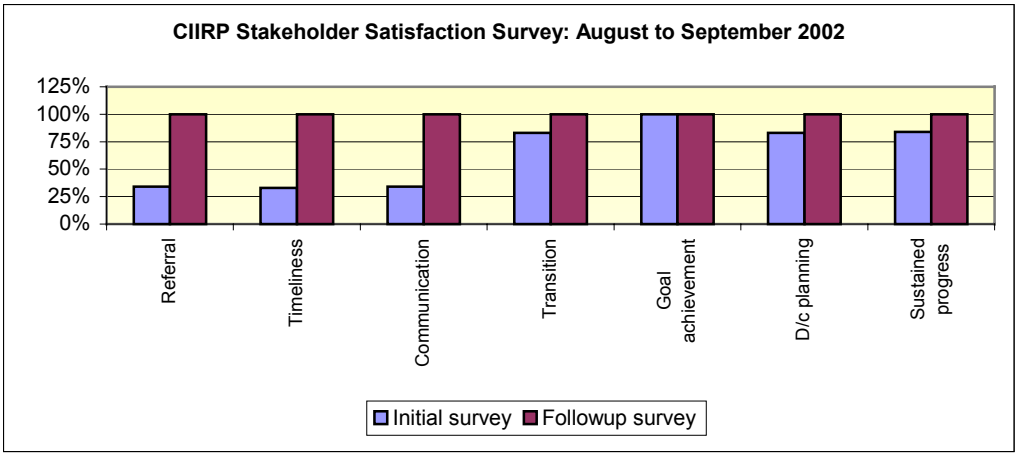


Figure 7.4-21 CIIRP Stakeholder Survey

7.4.c. Supplier and Partner Results – The Medical Center continuously trends and monitors key measures of the supplier and partner distribution chain. Areas of particular interest that have achieved outstanding performance and cost saving results lie within pharmacy mailout, home oxygen vendors, and reduction in average inventory stock on-hand.

Consistent with JCAHO requirements, contract management is vital to ensure that services are provided in a safe, effective and efficient manner at the highest quality possible. The survey of patients receiving pharmacy demonstrates that the service delivery is acceptable and in some cases exceeded expectations. Timeliness of pharmacy delivery was addressed through re-education to patients regarding their expectations and increased their awareness of the cycle delivery times.

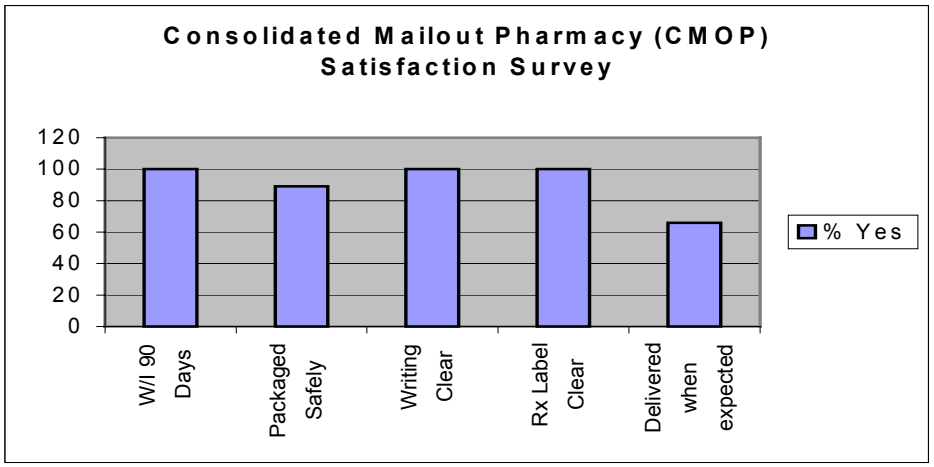
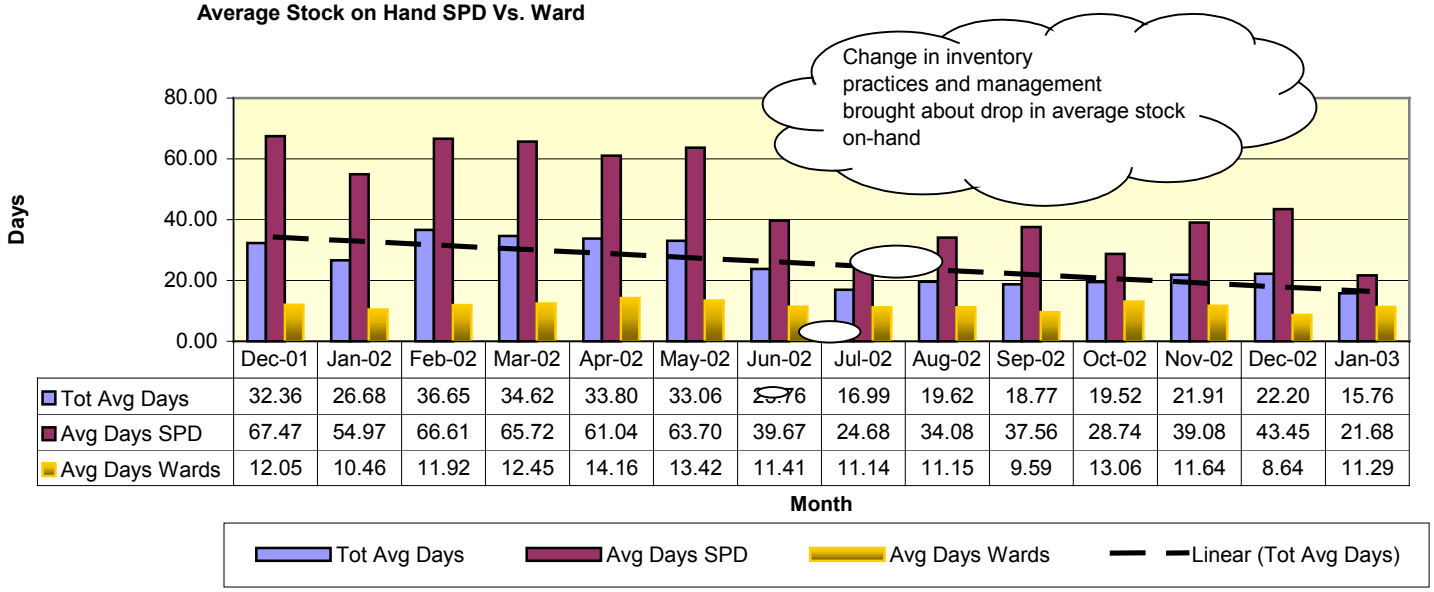


Figure 7.4-22 Consolidated Mail Out Pharmacy (CMOP)

Data was compiled for average stock-on-hand for both patient wars and Supply Processing and Distribution (SPD), as a VISN monitor, with a goal of 30 days or less. As indicated in the pareto analysis of wards & SPD, SPD was grossly in excess of goal, averaging 60 plus days. In June 2002, a "Just-In-Time" (JIT) inventory management system was implemented, and dramatic results ensued. The SPD average dropped from 67.5 days in December 2001, to 21.6 days in January 2003, for an average of 15.7 days, 50% less than the VISN goal.



	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03
Tot Avg Days	32.36	26.68	36.65	34.62	33.80	33.06	~~20.~~76	16.99	19.62	18.77	19.52	21.91	22.20	15.76
Avg Days SPD	67.47	54.97	66.61	65.72	61.04	63.70	39.67	24.68	34.08	37.56	28.74	39.08	43.45	21.68
Avg Days Wards	12.05	10.46	11.92	12.45	14.16	13.42	11.41	11.14	11.15	9.59	13.06	11.64	8.64	11.29

Figure 7.4-23 Average Stock On-Hand SPD vs. Ward